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Minnesota Medicine

A JOURNAL OF CLINICAL AND HEALTH AFFAIRS

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INFORMATION OVERLOAD

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Minnesota Medicine

Published monthly by the Minnesota Medical Association

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Criterion Clarifications

I am writing on behalf of Criterion HealthCare Network. We very much appreciated the recent article in *Minnesota Medicine* discussing this new health care initiative and its importance to independent physicians in the Twin Cities (November 1993).

There are two points concerning Criterion HealthCare Network which, if possible, should be clarified for your readers. First, Criterion HealthCare Network went through a name change. We were originally known as Spectrum HealthCare Network. These are one and the same organizations.

Second, many individuals have worked in partnership with Frank J. Indihar, M.D., in the planning and development of Criterion HealthCare Network. These include Andrew J. K. Smith, M.D., its chair; Victor A. Corbett, M.D.; John A. Dowdle, M.D.; David W. Grube, M.D.; Timothy S. Komoto, M.D.; Timothy F. Lane, M.D.; Wayne F. Leebaw, M.D.; Donald Pilarski; Douglas M. Soderberg, M.D.; Richard E. Streu, M.D.; and Jack L. Strobel, M.D. It certainly would be appropriate to recognize the enormous contributions of each of these individuals on behalf of their colleagues.

Douglas A. Shaw
Principal business consultant
Criterion HealthCare Network, Inc.
Minnetonka, Minnesota

Malpractice Leads to Painful Search for Self-Regard

I read with interest the painful Perspective's piece, "Malpractice Nightmare: Good Medicine Didn't Protect Me," in the November 1993 issue of *Minnesota Medicine*. The doctor has just begun a long journey in search of the core of her self-regard and her courage. She has found limited consolation in the knowledge that her medical strategies were solid. She has articulated well the unfortunate consequences of poor strategic management of harassment. Now her continued sense of shame may be keeping her on a self-defeating path.

The author's advice to the leadership of the Minnesota Medical Association is sound and should certainly be pursued. As for the author, she should insist on being part of that support group. The MMA has expressed an interest in drawing upon its female membership to facilitate such activities. Let's get started.

Rachel W. Trockman, M.D.
Staff physician
Pediatrics Department
Hennepin County Medical Center
Minneapolis, Minnesota

Malpractice Support Initiatives Underway at MMA

The author of "Malpractice Nightmare: Good Medicine Didn't Protect Me" makes some good points in the November 1993 issue of *Minnesota Medicine*. She suggests that the Minnesota Medical Association consider six initiatives. I would like to respond to each of them as follows:

1. The author suggests establishing a support group for physicians who are going through a suit or have been through one. The Minnesota Medical Association is currently establishing such a support group. This initiative is being established through the Minnesota Physicians Foundation.

2. The author suggests offering seminars on what physicians should expect when being sued. I agree this is a good idea. Multiple seminars have, in fact, been held around the state dealing with prevention of malpractice suits, but, unfortunately, they have not been very well attended.

3. The author would like the MMA to work to "reduce the long wait physicians must endure before receiving judgment from the Board of Medical Practice." The MMA has been working closely with the Board of Medical Practice for many years in dealing with such issues. The BMP functions under the state Administrative Practices Act, and legislative action may be necessary to reduce the wait.

4. The author would also like to see elimination of the National Practitioner Data Bank. This is already American Medical Association policy. The author is right on.

5. The author asks that the MMA provide a list of psychiatrists experienced in helping physicians who are being sued. The Minnesota Psychiatric Society has already developed such a list of psychiatrists. This list is available through the Minnesota Medical Association. It has been our policy to create such a list, and we appreciate deeply the efforts of the Minnesota Psychiatric Society in this endeavor.

6. The author calls for malpractice reform, for which the MMA has been advocating for many, many years. A commission developed by the MMA in 1985 brought about numerous changes in the laws in 1986. It is now our

policy to adopt legislation similar to MICRA, as adopted a few years back in California. The details have been well publicized in various MMA and AMA publications.

Additionally, I simply must respond to two other points the author makes. She states in her article that she told the chief executive officer of her hospital that it was no one else's business whether she had been sued. I totally disagree. Definitely it is the hospital's business. The Joint Commission on Accreditation of Healthcare Organizations and most hospital insurance companies demand that the medical staff provide this information.

Finally, I am disturbed by the author's quote, "I wish I were anything but a physician, and I make the point vehemently any time a starry-eyed student asks me about becoming a physician." I, personally, am very proud and happy to be a physician, and extremely proud of my profession and of Minnesota physicians in particular. And, yes, I have been sued, and I agree it is not a pleasant process. I hope that we physicians can stimulate young people to enter our profession rather than discourage them.

Thomas A. Stolee, M.D.
Past president
Minnesota Medical Association
Pathologist
Arrowhead Pathologists, P.A.
Duluth, Minnesota

'Malpractice Nightmare' Doesn't Ring True

As an attorney whose practice has been limited to representing patients in claims against physicians and other health care providers, I am interested and concerned about the anonymous article entitled "Malpractice Nightmare" from your November issue. Somehow the subtitle, "Good Medicine Didn't Protect Me," just doesn't ring true. In the first place, since 1986, a lawsuit cannot be filed against a physician unless another physician has been consulted by an attorney, has reviewed the facts underlying the claim, and has concluded that the claim is potentially meritorious. While this "affidavit of expert review" is not foolproof, it has resulted in the elimination of countless frivolous claims in Minnesota. To suggest, as this physician does, that the claim against her was frivolous, doesn't make sense.

In addition, in the countless hundreds of cases I have settled with the major insurers in Minnesota who cover physicians, I have yet to encounter one where the case has been settled absent the insurer's own independent review establishing the likelihood that negligence in fact occurred. If, indeed, this case settled for $40,000 six weeks after the insured spoke to her agent, without so much as meeting with the agent to discuss the merits of the claim, let alone without another doctor reviewing the case, it would be a first-time experience for me.

The author's concern about the National Practitioner Data Bank is also, in my experience, an overreaction. The public is denied access to this information. Only hospitals can obtain Data Bank information on a physician's claims experience, and only when the physician is seeking privileges at a different institution. Barring repeated negligent conduct by a doctor, it is highly doubtful that a hospital would ever take action based on the limited claims experience of this physician.

Likewise, this physician's concern about the Board of Medical Practice taking any retribution against her is exaggerated. If this doctor is upset about a one-year delay in her hearing from the board, just imagine what a complaining patient experiences. While I don't deny that being publicly disciplined in a small town might affect someone's livelihood, this would only occur after the physician was afforded a due process hearing and an opportunity to respond to any concerns that the board might have. Didn't the lawyer she hired tell her that? The fact is that the board only infrequently slaps the hands of doctors who commit far more egregious acts than whatever actions this physician may have committed, if any, in bringing about the death of an elderly patient.

Having said all of the above, I am still somewhat sympathetic for the physician and what she obviously went through. I have spoken many times to doctors at medical seminars about what is involved in a lawsuit against them, how the process works, and what they need to be concerned about and not concerned about. I strongly feel that the medical schools and hospitals in this community should encourage continued dialogue between our professions so that physicians, such as the one involved here, are not overly frightened by the process. No physician, or lawyer, for that matter, enjoys being sued for professional misconduct. It is, however, the risk of doing business, and we must all appreciate that any of us can make mistakes that cause injuries to others. What is required is for each of us to develop a level of self-confidence in our abilities so that a mistake in one instance will not cause us to doubt our ability to serve others. Nor should such a mistake, or even responding to a so-called frivolous lawsuit, cause us to view other patients or clients with the myopic vision that they are the enemy.

John F. Eisberg
Attorney
Robins, Kaplan, Miller & Ciresi
Minneapolis, Minnesota

When a Physician Errs

I am writing to respond to the article that appeared in your November issue entitled "Malpractice Nightmare: Good Medicine Didn't Protect Me."

I empathize with the author.

LETTERS continued on page 30

Minnesota Medicine

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Managing the Information Onslaught

'Just Say No' and Other Humble Tips

Charles R. Meyer, M.D.

When eating bamboo sprouts, remember the man who planted them.
–Chinese proverb

My keyboard fingers tremble slightly as I assume the editorship of *Minnesota Medicine*. For someone who likes to keep a low profile, making noise that can be heard at such a distance is intimidating. But I am comforted by the seeds that have been planted by previous editors. Although *Minnesota Medicine* has had seven editors in its 76-year history, I have personally known only the last two, Dick Reece and Ed Burke. Through his 16 years as editor, Dick brought the journal puns and perceptivity as he described the maelstrom of medicine in Minnesota. For the past three years, Ed has guided us with calm wisdom as the journal matured. *Minnesota Medicine* is a quality state medical journal because of its leadership. As *Minnesota Medicine* grows in the coming years, I will be ever grateful for Dick's and Ed's green thumbs.

We hope to nurture this growth by continuing to bring quality clinical articles, expanding coverage of the health care revolution that is our daily life in Minnesota, and stimulating a little healthy controversy in these pages. It should be fun.

This month's cover story (page 10) is a siren warning to any neophyte editor, asking all who put print to paper to ponder whether we are contributing unnecessarily to the information glut. Author Ralph Heussner details the imposing task physicians face in attempting to "stay current." The physicians with whom Heussner spoke bemoan the volume of information they feel compelled to digest.

The information avalanche is not unique to medicine. Drop by Barnes and Noble Bookstore and gaze at the

"Our cover story is a siren warning to any neophyte editor, asking whether we are contributing unnecessarily to the information glut."

selection of periodicals available. Tune in to the 50 cable channels, or the 100-plus channels if you have a satellite dish, although you may debate the use of the word "information" to describe these offerings. Staying current or well-informed in today's society is no longer possible with a simple reading of the breezy prose of *Time* magazine. Issues are so complex, it is difficult to feel that you know anything well enough to form an opinion.

Heussner's article focuses on clinical medical knowledge, but politics and economics are expanding physicians' "need to know." Comprehending HMOs and PPOs was tough enough, but these are becoming archaic, shoved aside by the latest acronyms: ISN, PHO, IHA. I suspect that three-letter "words" are rapidly supplanting four letters as obscene in the minds of physicians.

Heussner makes some suggestions for keeping up. A sidebar describes electronic CD-ROM offerings to ease access to the medical literature. The computer and the electronic highway do make large amounts of information available in a simple format (although the information still can be overwhelming). Heussner's remedies—a circulation club, a surveillance program, critical appraisal skills, and selected reading—are well-directed. To these I would add:

1. Prioritize. Most of us knew one student in medical school who read "Harrison's Textbook of Medicine" cover-to-cover. This is not setting priorities. Only a fraction of what is published is important to anyone. Decide what you need to know, what you don't know, and what interests you. If the article doesn't fit any of those, let it be.

2. Develop the ability to "just say no" to journals that have a high percentage of junk and, therefore, don't merit even a cursory glance. Most information related to your field contained in "throwaways" will appear in your specialty journals in a more comprehensive form.

3. Recognize the difference between information, knowledge, and wisdom. Raw information is useless unless you can do something with it. Knowledge is the structured application of information (or, perhaps, "the small part of ignorance that we arrange and classify," as the cynic Ambrose Bierce said). Wisdom applies judgment to knowledge. As William James said, "The art of being wise is the art of knowing what to overlook."

At *Minnesota Medicine* we hope to provide information that can be processed into knowledge. With a little luck, maybe we also can provide a glimpse of wisdom. MM

Hook Up Your Modem, Turn On Your Fax

By Pamela Hill Nettleton

Though still a believer in the value of the printed page, Minnesota Medicine*'s new editor-in-chief doesn't shy away from high-tech gadgetry that can help physicians communicate.*

Minnesota Medicine's new editor-in-chief, Charles R. Meyer, M.D., is a bit of a techie. Fascinated by electronic gadgetry and devices and intrigued by their applications in medicine, he can often be found sitting in front of his computer.

"Doctors don't tend to embrace personal technology—like faxes and computers—rapidly or easily," says Meyer, an internal medicine specialist with Consultants–Internal Medicine, P.A., in Edina. Despite having to adapt almost constantly to technological advances in medical treatment, pharmaceuticals, and the equipment associated with patient care, physicians don't seem to take to newfangled contraptions in the office or home setting very well—perhaps because learning to use them takes time, a precious commodity in a busy practice.

"Back when we first put our fax in here, people didn't see what use it would have in a doctor's office. Now, most days, that thing's smoking!" says Meyer, who looks forward to increased personal computer use in physician offices, linked networks with other physicians, and even to artificial intelligence-aided diagnoses and treatment.

As Meyer assumes the editorship of *Minnesota Medicine* this month, he brings with him a long-time interest in personal technology, as well as 16 years of experience in internal medicine. A partner in Consultants–Internal Medicine, he has served in a number of medical staff leadership positions, including chief of staff at Fairview Southdale Hospital and at Metropolitan-Mount Sinai Medical Center. He has served on a number of Hennepin County Medical Society ad hoc committees, is a member of the *Minnesota Medicine* Advisory Committee, and has written a number of articles for *Minnesota Medicine* and medical staff newsletters.

Born in Chicago, he jokes that he is the "underachiever" in a family of "overeducated, overachievers." His father graduated from Massachusetts Institute of Technology and still serves on the board there; his sister and brother attended Stanford University. His sister went on to Yale Law School and practices law in Washington, D.C. His brother attended Harvard Business School and recently retired at the age of 41. Meyer himself attended Princeton University, graduating in 1970. He received his medical degree from Northwestern University in 1974 and did his internal medicine residency at Mayo Graduate School from 1974 to 1977. He and his wife, Carolyn, a former music teacher and professional volunteer, have three children: Hilary, 16; Graham, 14; and Ramsey, 12. They live in Edina.

"I'm one of those people who decided early in life what I wanted to be, and I just stayed on track most of the time. When I was 8 or 9

PHOTOGRAPH BY BRUCE BAIRD

"Minnesota Medicine *will have to be a conduit for changes taking place in our state.*"

–CHARLES MEYER, M.D.

years old, my grandparents and a cousin died, and I wrote in my diary then that maybe I wanted to be a doctor."

Today, medicine is vastly different from the days Meyer first envisioned himself as a physician, but Meyer is changing with the times. Always looking for a new challenge, he has enthusiastically taken on the editor-in-chief position at *Minnesota Medicine*—a demanding role during this era of information overload.

Medical Journals in Today's Information Society

"Medicine needs to talk to itself more often," says Meyer, who is interested in exploring how the judicious use of technology and medical publications can make that happen. But, he notes, medical publications must not contribute to the glut of printed information piling up on the desks of physicians each day.

"The problem with the glut is twofold," says Meyer. "First, it's pure volume. Physicians receive incredible amounts of mail, have maybe 15 magazine subscriptions, discover four books a week we'd like to read. Trying to do all this and keep life in order is almost impossible. Everyone experiences this, in all fields.

"Second, medical technology is developing at such a rapid pace. It's very hard to keep up. The key, like anything in life, is to decide what is important and focus your energies there."

To help physicians do this, Meyer says *Minnesota Medicine* must stay committed to publishing material that is of high quality and relevance. "For most people, I think *Minnesota Medicine* is an important source of certain kinds of information. Although we have clinical articles in every issue, we know we can't compete with the specialty journals. The topics we publish typically apply to specialties across the board and are usually on public health topics or large topics that affect many specialties, like AIDS. Occasionally, the articles may be more specialized, but then they tend to be unusual or interesting case reports submitted by Minnesota physicians," Meyer explains.

"I'd like to see us be a little more controversial, generate a few more letters to the editor, support the lively exchange of viewpoints and ideas on critical medical topics. As the official Minnesota Medical Association journal, we do have a bit of a balance to strike, but I don't necessarily think that should deter

MEYER continued on page 41

Call for Papers

1994 International Conference on Physician Health
September 16-20, 1994. Ottawa, Ontario, Canada

"Stress: The Profession, the Family and You"

The 1994 International Conference on Physician Health, co-sponsored by the American Medical Association, the Federation of State Medical Boards, the Canadian Medical Association, and the Federation of Medical Licensing Authorities of Canada is scheduled for September 16-20, 1994, at the Ottawa Westin Hotel.

Ottawa is Canada's capital and offers many national museums, over 60 miles of bicycle paths, hiking in Gateneau park, squash courts and swimming at the hotel and golf nearby.

The conference will provide a forum for practitioners and researchers to present recent findings and innovative treatment and education programs in physician health. This conference will address a range of issues, such as AIDS, HIV, problems related to aging, mental illness, substance abuse and physical disabilities and limitations, including those caused by general medical conditions. Possible topics for presentation include: presentation and treatment of health problems among physicians, the impact of disorders on physicians' families and practices, medical-legal issues facing hospital administrations and licensing boards, and material on health promotion and disease prevention. *Abstracts which address issues related to these topics (i.e., prevention, diagnosis, treatment, rehabilitation), but not dealing specifically with physicians are also welcome.*

Three types of presentations regarding these physician health issues are invited:

- **Poster Presentations**
  Written presentations of data-based research, epidemiological research, or program descriptions.

- **Paper Sessions**
  Oral presentation of scientific, data-based findings relative to the topic of physician health.

  Abstracts for poster presentations and paper sessions should contain an introductory statement on the significance of subject matter. Description of methods, results, and conclusions should follow the introductory statement.

- **Workshops**
  Training or instructional presentations, designed to improve specific skills of persons who work in the area of physician health.

  Abstracts for workshops should contain information on the program's intended audience, goals, teaching strategies, and materials. Evaluation data should be summarized

Abstracts may not exceed 200 words. Any abstracts exceeding that length will be rejected. Abstracts should be typed, double spaced, and mailed (not faxed). Four copies of the abstract should be sent, along with one self-addressed, stamped envelope. All submissions must list the primary and secondary authors and their professional affiliations. Telephone number and address of primary author must also be included.

Submissions *must* be received by February 1, 1994.

Abstracts will be submitted for blind review. Abstracts will be judged on their applicability to the conference topic area and their scientific merit. The decisions of the blind reviewers will be communicated to the abstract's primary author by April 1, 1994.

All presenters are expected to register for the conference at the AMA member rate. We are unable to provide any financial support for presenters. Presenters will also be responsible for their own transportation and hotel expenses, as well as making all reservations for same.

Send all materials to:
Elaine M. Tejcek, Physicians Health Foundation, American Medical Association, 515 N. State Street, Chicago, IL 60610.

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Snowbound Soliloquy

By Edmund C. Burke, M.D.

You can't arrange it. You can't do anything about it when it happens. But you can recognize what an exquisite gift nature has given you. Snowbound!

I have no choice. I am obliged to sit, look out the window, and ponder. How little it matters what I had expected to accomplish before this snow arrived.

I am lucky, I decide, since I am at my home on Lake Pepin—a special place most folks associate with summer boating, water skiing, and fishing. This winter morning is ethereally peaceful, tranquil, beautiful. Only occasionally do I hear a truck or plow rumble down the highway nearby, or a muffled *whoosh* of an overhead jet—Chicago bound. There are no other sounds, just sights. The only movements are the feeding birds.

ILLUSTRATION BY REGULA RUSSELLE

Anyone who hasn't taken to feeding winter birds is missing out. Perhaps this is an obsessive activity of older folks concerned with life. I prefer to regard it as a heightened awareness of my environment.

At the suet feeders are assorted species and sizes. Woodpeckers quickly flit on, off, and away. Goldfinches, juncos, cardinals, nuthatches, chickadees, sparrows, starlings, finches, even an occasional blue jay, come and go at the seed feeders.

The blue jay rapidly touches down like a four-star general. He scatters all the other birds. Not only is he larger, but he also has an imperial bearing, even imperial coloring. He is a fancy dandy (reminds me of some politicians).

Oh yes, another character appears—the resident fox squirrel. He needs food, as do the others. He is aggressive, and there is no denying his presence as he sits at the feeder munching away to heart's content.

A curious thing, which I hadn't realized until a few years ago, is that different species do not feed together. Bigger, aggressive birds drive off the smaller birds. A pecking order truly exists. Humans didn't invent it, but we utilize it.

Suddenly, a wing-flapping, beak-beating confrontation takes place at the suet feeder between a red-bellied woodpecker (arrived first) and a starling. The starling is driven off, but only this one time. First come, first served!

The severe floods of last summer, which ruined my gardens and lawns, are only a distant memory. As I gaze out on the serenity and peace of the morning, there is a snow covering, bow bending of evergreens. They appear to be covered with cotton batting—a Christmas card picture that unfortunately won't last. Man could never invent anything like this.

The greening with spring, the transformation from arctic to Eden, will be spectacular—a spiritual experience. But a winter storm rarely receives its full share of credit. Admittedly, it temporarily disrupts life, but isn't that its glory? Without the snowstorm, I would not have had reason to sit here and take measure of an exalting moment. Snow plows and tomorrow will come all too soon. MM

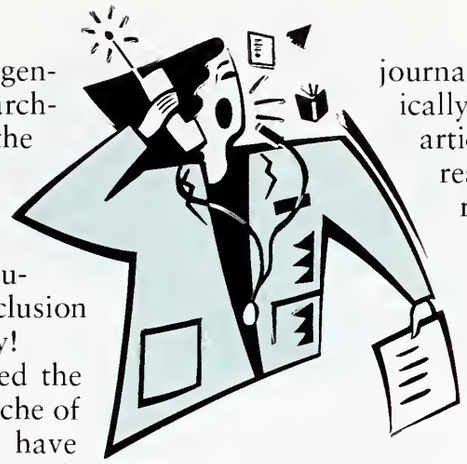
Edmund Burke is former editor of Minnesota Medicine *and an emeritus professor at Mayo Medical School.*

COPING WITH INFORMATION OVERLOAD

In 1979, the head of the library department at the State University of New York, Buffalo, constructed a series of mathematical formulas to describe the virtual explosion of articles in the biomedical sciences. With 4 million articles published annually in 70 languages, he determined that a physician would have to read 5,500 articles per day to read everything of relevance in medicine. Put another way, if a practitioner read or scanned only two articles a day, she would fall 55 centuries behind every year.

• • •

Ralph C. Heussner Jr.



The librarian concluded: "For the general practitioner and for the researcher who wishes to keep up with the entire biomedical literature, the situation is hopeless—even with the help of abstracts and extracts."[1]

Of course, any first-year medical student would have come to the same conclusion after just one trip to the medical library!

Numerous studies have documented the difficulty of keeping up with the avalanche of new medical information, and most have reached the same conclusion as a World Health Organization task force on physician education: "Available evidence suggests that the major deficiencies in health services occur not so much because knowledge has not been disseminated, but because it is not used."[2]

For example, 18 months after publication of a definitive study establishing the efficacy of photocoagulation in the management of diabetic neurovascularization of the retina, physicians attending a university-sponsored continuing education course were asked if they knew the results of the study.[3] Less than half the internists and only a fourth of the general practitioners knew about the study, and even fewer physicians could correctly answer questions concerning application of the results. The responses of physicians who had more than 50 patients with diabetes in their practices were nearly the same as those who had only a few. Similar surveys have found the same gap in the application of knowledge in cardiology, oncology, and other specialties.

Physicians who attempt to "keep up" with the medical literature seem to be fighting a losing battle. And no one is surprised.

"The bottom line is that a busy clinician in private practice has no designated time in the day for reading, or even scanning, the medical literature," says one physician. "You are not paid to read; you are paid to see patients and deal with their clinical problems in the fastest, most efficient way possible. That's the sad truth."

The sheer number of articles is burdensome, but perhaps more confounding is finding the useful information in the mounds of available material, says David Knopman, M.D., associate professor of neurology at the University of Minnesota. As he puts it, "Separating the wheat from the chaff becomes more challenging all the time."

Keeping Up With the Literature

Surveys indicate that most physicians spend an average of two to three hours a week reading or scanning medical journals or other publications. Physicians typically scan a publication's index, then flag articles of interest. If time permits, they will read the abstract. Most will then file the relevant articles for future reference.

Brainerd family physician David Boran, M.D., says he gathers journal articles about twice a month to pursue a particular topic in medicine. The subject is usually prompted by a patient problem. "When I was a resident, I was always carrying journal articles around in my pocket. I even developed my own cataloguing system for relevant publications, but since going into practice 15 years ago, I have probably updated it once," he says.

Chris Sullivan, M.D., an infectious disease specialist at St. Paul-Ramsey Medical Center, estimates that he spends up to five hours a week scanning various pieces of medical literature. He follows up with one week of intensified reading and study in a particular area of infectious diseases every year. This year, he traveled to St. Petersburg, Russia, for an international meeting on streptoccocus; last year he studied recent developments in tuberculosis at the National Jewish Hospital in Denver. "This has been very helpful because I have a chance to read about new developments in science and get a finger on the pulse of what the latest is. In addition, I familiarize myself with the names of people I can go to for answers," Sullivan says.

> "In the day-to-day management of patients, you rely on your own experience plus input from your colleagues."
>
> –*Chris Sullivan, M.D.*

As an academician and researcher, Knopman sees himself as someone who should be ready with answers. Because he needs to keep abreast of breaking developments in basic science that could affect his research in Alzheimer's disease and cognitive neurology, he tries to be aware of all new developments before they become the standard of care. He routinely reads or scans five neurology journals, two geriatric journals, *Nature*, and *Science*.

"My technique is to scan the journals for 'hot articles,' which I will read," says Knopman. "Then, every

few months, I try to input the titles and abstracts of key references into my own computer system for further reference."

Bits, Bytes, and Throwaways

Besides receiving subscription journals, physicians are also bombarded by the so-called "giveaway" publications, including newsletters, promotional pamphlets, and other printed material. Physicians interviewed for this story said they don't automatically toss unsolicited journals (which have also been termed "throwaways") but will scan the index for articles of interest or relevance. "If I recognize the authors as people who are well-known experts in a field, I save the article for future reference," says Sullivan. In fact, surveys have shown that unsolicited medical literature is used extensively, particularly by those in rural, solo practices.[4]

Although commonly criticized for its coverage of medical science, the news media also contribute to the physician's learning process, several doctors note.

Says Boran, "I will often follow up on media reports of medical articles and actually read the journal. However, I often find that the article the press is reporting on is not as important as something else that I find in the journal."

One physician even cited the *Wall Street Journal* as a good source of medical news. "On the way to checking the stock quotes, I might learn of a recent medical breakthrough," he muses.

Although the printed page remains the predominant means of disseminating medical information, the scientific word is also being spread by such high-tech means as bits, bytes, and satellites. Extracts and abstracts are available on FM educational radio, television, audiocassettes, optical disks, and via special satellite teleconfer-

Do Your Reading at Your Terminal

New computer technology means new ways of transmitting medical information. You can now receive several months or years of select journals on CD-ROM (an acronym for compact disk-read only memory) that can be used with IBM-compatible computers. A laser beam in the hardware scans the high-density disk, which stores much more data in a more durable format than a magnetic floppy diskette. The disks include searching software to help locate relevant articles, which you can print.

The information is not as current as online databases, such as MEDLINE or Grateful Med, because the disks are sent out periodically. Most are updated either quarterly or annually. But recently, the American Society for Microbiology began offering all 10 of its journals monthly on a single disk.

The cost of a CD-ROM journal also varies. Macmillan carries several major journals (e.g., *New England Journal of Medicine*, *Lancet*, *Annals of Internal Medicine*, and the *Journal of American Medical Association*) for $495 per year each. The *AIDS Compact Library*, which includes more than 7,400 articles from nine major publications, is $855 per year. CMC Research offers *American Family Physician* for $305 per year.

Other CD-ROM systems include the *Science Citation Index*, which covers more than 3,300 journals and is updated quarterly; *Cancer-CD*, with all cancer-related literature; and *Biological Abstracts*, with current research in both the biological and biomedical literature.

Another method of translating information was introduced last year by the American Association for the Advancement of Science. Its *Online Journal of Clinical Trials* transmits reports of new clinical trials as soon as they are accepted for publication. Subscribers with fast personal computers, color monitors, and a powerful modem can have instant access to this data, but for a substantial fee of $3,000.

For physicians who are curious about the new computer technology, the University of Minnesota's Biomedical Library offers CD-ROM searching, as well as access to the online service.

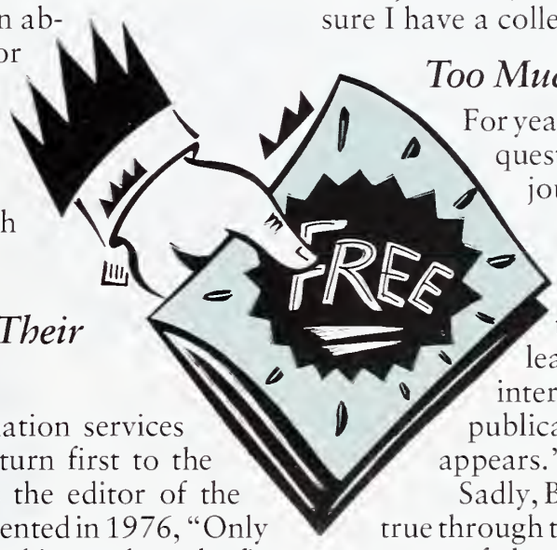
—RCH

ences and computer (see sidebar, page 12).

The most widely used computer system is MEDLINE, the electronic version of *Index Medicus*. The comprehensive database contains mostly clinical articles gleaned from 3,200 peer-reviewed journals. However, a MEDLINE search is still problematic; the computerized index contains approximately 300,000 articles for each of the past five years.

Physicians would find MEDLINE more helpful, suggests University of Minnesota medical librarian Julia Kelly, if they developed better search skills. "The most important step in finding an answer to your question in the journal literature is to formulate the question carefully. Be as specific as you can," Kelly wrote in a recent *Minnesota Medicine* article ("Searching for Answers: Using Computers to Find the Literature You Need for Patient Care," October 1992, page 39).

John Kluznik, M.D., a forensic psychiatrist at the Minnesota State Security Hospital in St. Peter, Minnesota, subscribes to an abstracting service that searches for special articles of interest in psychiatry, genetics, and AIDS in mainline peer-reviewed publications. He receives about 15 articles a month in these areas, which he reads thoroughly.



Where Do Docs Turn With Their Questions?

Despite the vast array of information services available, physicians claim they turn first to the traditional journal. However, as the editor of the *Annals of Internal Medicine* commented in 1976, "Only a naive editor could think of clinical journals as the first source of information in the day-to-day work of the busy clinician."[5]

Although physicians often tell surveyors that medical journals are their primary source of information, a group of researchers at the University of Southern California discovered otherwise by actually observing and then interviewing 47 physicians during a half day of a typical office practice.[6] All but one of the 47 physicians reported a need for outside information in managing patients; most of their questions dealt with problems outside their specialty. And where did they go for the answers? "Other physicians are the commonest providers of needed information in office practice," the study concluded.

Minnesota physicians interviewed for this article follow the same modus operandi when confronted with a diagnostic or treatment dilemma.

"If a difficult case arises or if I have a question, I'm more inclined to consult a colleague," says Boran. "For example, if I had a patient with TB, I would contact one of our internal medicine people or infectious disease physicians to see what medications are currently recommended."

Sullivan takes a similar approach: "In the day-to-day management of patients, you rely on your own experience plus input from your colleagues. I will take a case as far as I can, then seek advice from a subspecialist. If I have time to read, I'll do that. But in most clinical problems related to diagnosis and care, I will only refer to journals if the subspecialist and I reach a fork in the road and we don't know where else to turn."

Kluznik is periodically on call for general medicine for all patients at the St. Peter security hospital. "I do my best to have a general knowledge of new developments in major areas," he says, "but when I'm on call, I make sure I have a colleague to contact if I need help."

Too Much Information

For years, editors, physicians, and others have questioned the need for so many medical journals and "giveaway" publications. Nearly a century ago, John Shaw Billings, the first director of the National Library of Medicine, said of the medical literature, "nine-tenths, at least, of it becomes worthless, and of no interest within ten years after the date of its publication, and much of it is so when it first appears."[7]

Sadly, Billings' observation seems to have held true through the years; an estimated 25 percent to 50 percent of the scientific papers published are *never* cited again.[8]

If busy physicians don't have enough time to read, and much of what's published is irrelevant, why does the information onslaught continue? Most editors and authors will offer a number of reasons, but key among them is the pressure to publish.

"I don't care what anyone says. There is still the pressure to publish," says Carol Olson, M.D., an instructor in internal medicine at the University of Minnesota. "Promotion and success in academic medicine are primarily based on your publications. My criticism is that quantity of articles seems to weigh more heavily than the quality of your publications. For example, when I was in California, I was asked why I didn't have more publications. They did not appreciate the fact that I had devel-

oped some basic science techniques that had been published in some very important basic science journals."

Olson's criticisms are shared by people on both sides of the publication equation. For example, Arnold Relman, M.D., editor emeritus of the *New England Journal of Medicine*, writes, "Researchers should be judged primarily by the quality and number of their real scientific contributions, not by the quantity of papers they publish. Unfortunately, however, scientists can gain recognition simply by publishing frequently, regardless of the quality or originality of their work or the importance of each publication."[9]

Knopman, however, suggests the information explosion isn't all bad. He believes that the ever-growing number of biomedical publications reflects two positive trends. First, more people are now involved in biomedical research. Second, the process of publication is more fair. "In my field, for example, there was a time when you only had one or two journals, and if you didn't have your paper accepted, then forget it. Today, there is broader representation of the work of researchers. The problem in science is that experts (reviewers) can't always perceive what is a great advance and what is not," Knopman argues.

Remedies

Beneficial or burdensome, the deluge of medical information continues, and keeping up is not a simple matter of reading faster. The average journal article is 2,000 to 3,000 words long, and speed reading is not very useful for technical material. The situation is not hopeless, however.

Continuing medical education programs offer physicians one way to deal with information overload. "I've always considered our review courses as basically providing a means for physicians who can't read all the literature to receive at least the highlights of information on the most important things that are happening in the field," says Bart Galle, Ph.D., director of continuing medical education at the University of Minnesota.

Boran credits St. Joseph's Medical Center in Brainerd with developing a useful continuing medical education program based on nine key topics that are continually recycled and updated. "I think this program has helped to keep me current. You have to remember that nothing happens overnight. Rarely will a journal study become the standard of care right away. There is usually discussion, some letters to the editor, and other reports." CME courses help put it all in perspective, Boran says.

Relman argues that physicians can stay "fully and reliably informed" in any clinical specialty simply by reading five or six properly selected, high-quality journals—one or two general medicine and the rest specialty journals.[10]

The *Annals of Internal Medicine*, which published a series of articles on managing information overload,[11] encourages all physicians to maintain a general medical knowledge by subscribing to one or two general medical journals because, "No matter how specialized a practitioner becomes, he or she should retain some knowledge of the major developments in other fields of medicine; patients seldom appear with a neatly packaged and defined problem." (See sidebar, this page, for a summary of the *Annals'* suggestions.)

Finally, physicians may want to consider subscribing to an abstracting service, such as Current Awareness, offered by the Biomedical Information Service at the University of Minnesota Biomedical Library. Subscribers to the service may request database searches for articles on any number of topics. Each month, subscribers receive a bibliography (and abstract, if requested) of relevant articles and may order copies of complete articles of their choice. For more information on Current Awareness services, call Vicki Glasgow, 612/626-3730.

The Future

Biomedical information overload will likely worsen.

Prescriptions for Reducing Information Overload

The following suggestions, based on a series of articles in the *Annals of Internal Medicine*,[11] may help physicians reduce information overload:

Form a "circulation club" in your practice. Each member agrees to subscribe to a proportion of the journals. Issues of each journal, with the key articles highlighted, are circulated among colleagues. An alternative to this plan is to circulate only the index or abstract.

Develop a "surveillance program." It could be a regular trip to a medical library, or contact with a medical librarian who knows your particular interests.

Develop critical appraisal skills. What articles are important?

Restrict your reading mainly to original journal articles.

Read only articles that would be of direct importance to your clinical practice.

Determine whether the results of clinical studies are likely to be true based on your own experience and knowledge.

When the New York library professor conducted his literature review in 1979, he noted that the number of articles in biomedical journals was doubling every 10 to 12 years.

"Sometimes, I feel like I need to take off a year just to catch up on my reading," laments one Minnesota physician.

Of course, even if he did, he'd still be several millennia behind! MM

Ralph Heussner is a medical writer and study coordinator of the AIDS Clinical Trials Unit at the University of Minnesota. He is also the author of four books.

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The Information Skyway

By Gordon M. Simanton

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Wireless technology is advancing medicine and communication in ways earlier generations could only have imagined.

On April 14, 1865, the 16th president of the United States, Abraham Lincoln, was assassinated. London, England, received word of this tragic event five days later. In March of 1981, Ronald Reagan was shot outside the Washington Plaza Hotel. Five *minutes* later, the London correspondent for the *Washington Post* informed his contact at the London newspaper that the president had been shot. Today, we take for granted the speed of communication, but it is extraordinary when compared with the past. In a little over 100 years, our ability to communicate and transfer information across the world has collapsed from days to minutes—and even seconds.

This time-lapse undoubtedly will be compressed even further. Wireless technology will allow the transpor-

tation of knowledge along a universal "information skyway" to one person or millions simultaneously. Cellular phones and alphanumeric pagers are already commonplace, and a new generation of technology is on its way.

What does this mean for physicians? Picture this: An ambulance arrives at the scene of a remote emergency. Video cameras mounted in the emergency vehicle transport images providing instant visual and audio transmissions to the trauma team at the hospital. While en route to the hospital, the paramedics continually transmit vital signs—heart beat, blood pressure, and EKGs—to the medical staff at the centralized location.

The medical community has always been a pioneer on the technology frontier and is often among the first to utilize new technology. Several decades ago, doctors were one of the first groups to recognize the benefit of telephones. This new technology made the doctor more accessible, ultimately saving lives. The same is true today, with health care practitioners utilizing the wireless telephone. Physicians, nurses, paramedics, emergency trauma teams, rural veterinarians, and patients have all witnessed firsthand the benefit of instant communication and its ability to save lives. These technological advancements, while tremendous, are still in an embryonic stage.

Technology not only has changed medicine, but also has changed the entire infrastructure of American society. The industrial revolution in the United States initially created a centralized social and economic climate. People moved from rural areas into central manufacturing areas to produce goods, which were then transported to the consumer by railroads and waterways. With the advent of the automobile and the development of the national highway system, we experienced a gradual migration from these urban manufacturing centers to the suburbs. This, in combination with air transportation, has further accelerated our move back toward a decentralized economy and society.

"New technologies will have a far-reaching impact on medical training in the future."

This continuing decentralization will have a profound effect on hospitals and will require reengineering of their organization. The challenge for hospital administrations in the future will be to embrace new technologies that provide the opportunity to decentralize accommodations for non-critical care patients to other public facilities or private dwellings outside major metropolitan markets. This will be accomplished by utilizing video conferencing, electronic monitoring, and the instant availability of records to chart patients' progress 24 hours a day.

New technologies will have far-reaching impact on medical training in the future. Simulation will become a key training component as medical institutions begin to take advantage of high-tech, soft-touch applications similar to the flight simulators used for years by the airline industry to train pilots. This practice is not unlike the recently introduced "Virtual Reality" game, which uses technology that actually allows the participant to be part of the game. Virtual reality will revolutionize the way we educate and train medical students. Consider:

• A medical student prepares for surgical training. She straps on the visette (headgear) and the image of a cadaver appears before her as she proceeds with a simulated appendectomy. Not only does the student see her own hands and instruments, but she actually experiences the operation. She may ask a colleague from Boston to assist in the operation, and both students will appear to be in the same operating room, even though thousands of miles separate them. Among the many benefits, such training would accelerate learning and reduce the need for cadavers or animals for experimentation.

• A primary care physician needing advice transmits his patient's complete record and medical images to a subspecialist. The subspecialist conducts a remote exam using a high-definition video conference, resulting in a faster, more accurate diagnosis for the patient.

• A patient is released to his home only hours after surgery. Through wireless technology, the medical team monitors his recovery minute by minute, and his chart is simultaneously updated and prescriptions ordered.

And, outside medicine:

• You received a call today from the school principal. Your daughter was caught during school using her wireless palmtop to fax a message to a friend in algebra class.

• An overnight package that was supposed to be delivered for an important regional meeting hasn't arrived yet. You pick up the phone and call the confirmation number. Your package answers the call and explains, in a calm voice, that it has just arrived at the Twin Cities airport and should be delivered to your office in an hour.

• You're working late; you're ready to go home. It's

February, and the thought of getting into a cold car is less than appealing. You pick up your wireless phone and call your car; you type in your security access code and start your car.

• The waiter approaches your table to take your order. He pulls out his wireless personal digital assistant and accesses the order form. He notes your meal selection, hits "send" on the key pad and instantly places your order on the electronic video wheel in the kitchen.

• A newspaper reporter works for a major publication firm headquartered in Los Angeles. The reporter lives in Santa Fe, New Mexico, and is writing a story about inner-city gang violence. She alerts her information network that she wants background print and broadcast information on this subject gathered and delivered via the information skyway. Her satellite dish allows her to retrieve current broadcast news information from around the world, and her video conferencing system enables her to meet with anyone on the subject.

• Utilizing the virtual reality concept, an architect shows a couple their newly completed home design. All three can enter the front door and actually walk through the simulated home together and make changes to the living quarters.

The new services, products, and applications made possible by wireless technology will be limited only by our imaginations. Applications for wireless products and services will grow throughout the next decade, dramatically improving our productivity. Although this new wireless technology will expand and enhance our way of life, some people will not perceive it as an important social or economic utility. No surprise—from a historical perspective, technology has never been initially received with open arms. The reaction to new technology is typically negative, as human nature defines tomorrow in terms of what we know today, resulting in the belief that technology hinders progress. In reality, technology and invention have always yielded personal freedom: The airplane lets us travel almost anywhere. Walkmans let us listen to music almost anywhere. The automobile lets us live almost anywhere. Personal computers let us work almost anywhere. Television lets people be informed and entertained almost anytime. Wireless technology will let us talk to anyone, anytime, anywhere, completely revolutionizing how we will work, learn, communicate, travel, and live in the future. MM

Gordon M. Simanton is director of sales and marketing for Cellular One in Minneapolis, a McCaw Communications, Inc., company.

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References

All references must be cited in the text and should be arranged in the order in which they are cited in the text—*not* alphabetically. Journals should be abbreviated as in *Index Medicus*.

Examples:

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Testicular Microlithiasis

A Case Report

Eduardo T. Fernandes, M.D., and Cesar J. Ercole, M.D.

ABSTRACT

A 63-year-old man presented with bilateral testicular microlithiasis and right-sided epididymitis, the latter of which responded to antibiotic and anti-inflammatory drugs. Microlithiasis has been associated with nondescent, infection, neoplasia, and other pathologic conditions of the testicles, but there is no evidence that it is a premalignant condition. It is likely to be seen more often with the increasing use of scrotal ultrasonography.

Testicular microlithiasis, which is characterized by calcified concretions within the lumens of seminiferous tubules, has been associated with germ cell neoplasms, nondescent, infertility, Klinefelter syndrome, pseudohermaphroditism, Down syndrome, compromised testicular blood flow, and pulmonary and brain microlithiasis."[1-8] However, it is typically an incidental finding during ultrasound investigation.[1] Because testicular sonography is now done frequently for the evaluation of possible torsion, tumor, epididymo-orchitis, and trauma, more cases of testicular microlithiasis may be identified, raising questions about the nature and proper management of the condition. We describe a case of testicular microlithiasis and present current views in etiopathology, diagnosis, and treatment of this condition.

Case Report

A 63-year-old Vietnamese man presented with a right scrotal mass and mild pain in the right testicle. That testicle was five to 10 times the size of the left one. The right epididymis was tender to palpation, and the spermatic cord was swollen and tender. Scrotal sonography disclosed right epididymitis with microabscess formation, a small right-sided hydrocele, and bilateral multiple hyperechoic lesions less than 2 mm in length (see Figure).

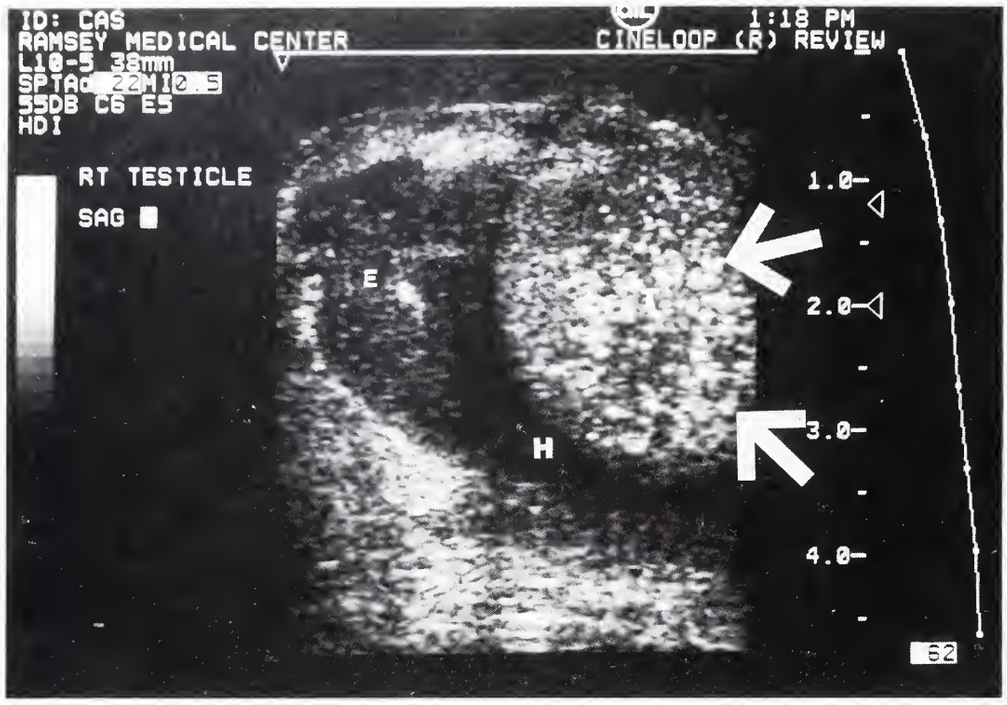
We diagnosed epididymitis and testicular microlithiasis. The chest radiographic examination was normal, as were the serum alpha fetoprotein and human chorionic gonadotropin concentrations. PPD testing was negative. We treated the patient with an oral antibiotic and anti-inflammatory drugs. Two-month follow-up showed resolution of the inflammatory lesions and continued presence of the microliths.

Discussion

The incidence of testicular microlithiasis is difficult to ascertain. The condition was found in 0.6% of 1,710 testicular sonographic examinations by Höbarth and coworkers,[2] in one of 2,100 autopsied boys and one of 618 testicular biopsy specimens by Nistal and associates,[7] and in two of 30 cryptorchid testes by Vegni-Talluri et al.[8] However, these numbers cannot be assumed to represent the incidence in the general population. On the basis of their series, Höbarth et al.[2] suggest that the incidence of testicular microlithiasis is higher than is reported in the literature.

The sonographic appearance of testicular microlithiasis is distinctive, consisting of bilateral multiple homogenous, nonshadowing, hyperechoic lesions measuring less than 2 mm,[9] a picture that has been likened to a snowstorm.[4] These concretions are formed by degenerating tubular epithelial cells that serve as a nidus for dystrophic calcification.[1] Other testicular lesions, such as granulomas, focal scars resulting from prior trauma or infection (epididymitis, orchitis), sarcoidosis, chronic infarction, and certain tumors (lipomas, benign fibromas, and teratomas), can also calcify and should be included in the differential diagnosis.[1,10] These lesions generally are larger, less numerous, and unilateral (microlithiasis is always bilateral).

The association of microlithiasis with subfertility,[1,3] infection, cryptorchidism,[6-8] intratubular germ cell neoplasia,[5] and frank tumor[1,2,4] has led some authors to suggest that all patients with microlithiasis need thorough evaluation[2-4] and close follow-



Figure—Right testicle (T) with multiple hyperechoic lesions (arrows). Note small hydrocele (H) and enlarged epididymis (E).

up.[1,4] However, it is not clear whether these associations are significant. Even though epididymal infection was present only on the right side in our patient, microlithiasis was seen sonographically in both testes, which suggests that the association between this infection and microlithiasis was coincidental. In two series,[1,2] patients with testicular microlithiasis were followed for many years, and none developed a testicular tumor. Janzen et al.[1] consider the association of microlithiasis with various testicular diseases coincidental and note that microliths do not impair sonographic detection or evaluation of testicular neoplasms in those patients presenting with both tumors and microliths. Smith and associates[9] suggest that microlithiasis is a primary process independent of any other pathologic condition of the testicle. The finding of calcifications in the lungs and brains of some patients indicates that testicular microlithiasis can be one manifestation of a systemic disorder.[7]

Although testicular microlithiasis frequently is associated with diverse testicular anomalies and neoplasms, the entity itself is apparently benign and self-limiting.[1] At the same time, microlithiasis is unlikely to be responsible for a patient's symptoms, so further evaluation should be carried out as appropriate. Conversely, if microlithiasis is found in a male patient of any age without scrotal signs and symptoms, no additional diagnostic test, biopsy, or follow-up seems to be required. It is not known whether microlithiasis is a cause of subfertility in some patients, or whether it is another manifestation of a process causing both germ cell destruction and calcification.

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Sterilization of Minors

Determining whether a parent can have a child sterilized is a complex children's rights issue that can create a legal dilemma for physicians.

Michelle Boynton, J.D.

The issue of children's rights is a burgeoning area of law that has recently received intensified national attention. Disputes regarding the rights of biological and adoptive parents, disputes over whether a child can "divorce" a parent, and numerous other children's rights issues have been the center of media attention recently. Among these many controversial children's rights issues is one some health care providers face in their everyday practices: the question of when a parent or guardian can have a child sterilized. The issue involves the rights of parents and guardians to determine what is in the best interests of a child, as well as the rights of children to procreate.

The issue of sterilization most often arises when a mentally disabled or physically disabled child enters the teenage years and the child's parents or guardians begin to contemplate how to handle the child's sexual awareness. Depending on the severity of the child's mental or physical disability, some parents or guardians conclude that it is best for the child to be sterilized. When a physician is asked to perform sterilization procedures on a child, the physician is faced with a legal dilemma: whether the written informed consent of a parent or legal guardian is sufficient to perform the sterilization, or whether a court order is required.

Requirements for a Guardian

Under Minnesota law, a legal guardian may not consent to the sterilization of a child until the guardian has obtained a court order approving the sterilization. From this requirement it follows that a physician should not perform any sterilization procedures on a minor unless both the written informed consent of the legal guardian and a court order approving the sterilization have been obtained.

It is the legal guardian's responsibility to request court approval for the sterilization. In determining whether to approve a sterilization request, the court will determine whether clear and convincing evidence shows that the sterilization is in the child's best interests. The court will consider written medical reports identifying the medical risks involved in the procedure and the alternatives available. The court will appoint a licensed physician, a qualified psychologist, and a social worker or case manager to assist the court in making the determination. These professionals will examine or evaluate the child and provide written reports to the court regarding why sterilization is being proposed, whether sterilization is necessary, whether sterilization is the least intrusive method for alleviating the problem presented, and whether it is in the child's best interests. The medical report must specifically consider the medical risks of sterilization, the consequences of not performing the sterilization, and whether alternative methods could be used to protect the child's best interests.

Requirements for a Parent

Often a child will not have a legally appointed guardian because the child's parents are the caregivers. In this case, a child's parent is usually the party requesting the sterilization procedures. Although Minnesota law dictates the steps a *legally appointed guardian* must take in order to have a child sterilized, it does not address what steps *parents* must take in order to have their child sterilized or whether the written informed consent of parents is sufficient to authorize a child's sterilization. Since Minnesota law does not address the issue, we must turn to case law in other jurisdictions to obtain guidance.

Under common law, parents have a right, as well as a duty, to protect and care for their children. Based on this principle, parental consent is usually sufficient to authorize medical treatment for children. However, when the medical treatment is not medically necessary or involves the child's reproductive capacity, some sort of legal authorization through a court order is often required. Courts in other states addressing the issue have concluded that parents do not have the authority to provide the necessary consent for the sterilization of their child, unless the parents have obtained a court order approving the sterilization.

In one case from Connecticut,

parents requested that a physician perform sterilization procedures on their three daughters. All three of the daughters were severely mentally retarded, blind, and deaf. The children had no useful communication abilities. One of the daughters had begun to menstruate and suffered from severe cramping as well as psychological distress over the menstruation. She could not care for her own hygienic needs, and it was highly unlikely that she would ever be able to do so. The other two daughters were expected to have similar difficulties. The daughters would be subject to grave risks should they become pregnant because they were unable to communicate with a physician about their own physical condition and would have to be put under general anesthesia to be examined internally. Due to their limited ability to communicate with a physician, contraceptives would not be a safe or reliable alternative. A number of social workers and physicians concluded that therapeutic uterectomies (sterilizations) for the daughters were "medically indicated."

In examining the issue of whether parental consent was sufficient to authorize the sterilization of a child, the court recognized that parents usually have the authority to consent to general medical treatment for their children. However, the court found that sterilization is a special case in which parental consent is not sufficient. The court explained that because the medical procedure of sterilization is a drastic measure that affects the ability of a patient to procreate, the Constitution protects the freedom of the patient to decide whether to become sterilized, and special procedural precautions are necessary to ensure the protection of the patient's rights. The court concluded that even though the parents were willing to provide the necessary consent, and medical professionals agreed that the sterilizations were medically indicated, a court order approving the sterilization was necessary.

Other courts have also concluded that parental consent is not sufficient for the sterilization of a child. In a case from Indiana, the parents of a mentally impaired 15-year-old boy wanted to have their son sterilized, and the Indiana Court of Appeals held that common law does not invest parents with the power to consent to the sterilization of their child, even though they sincerely believe the child's adulthood would benefit from the sterilization. Similarly, a New Jersey court examined the rights of parents to consent to the sterilization of their daughter who was seriously afflicted with Down syndrome. The court concluded that "it is ultimately the duty of the court rather than the parents to determine the need for sterilization." The court explained that "unlike the situation of a normal and necessary procedure, in the question of sterilization the interests of the parents of a retarded person cannot be presumed to be identical to those of the child, [and] for this reason, the court must be satisfied that the sterilization is in the best interests of the incompetent person."

Since neither Minnesota case law nor statutory law addresses the issue of whether parents have the authority to consent to the sterilization of their child, it is unclear whether a court order is required or whether written informed parental consent is sufficient for the sterilization of a minor in Minnesota. Based on case law from other jurisdictions, however, there is a fair chance that a Minnesota court examining the issue would determine that parental consent alone is not sufficient. Thus, the safest route for health care providers in Minnesota is to have both a written consent from parents and a court order before performing any sterilization procedures on a child. MM

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Advance Directives for Health Care

Minnesota's new Health Care Power of Attorney fills a gap for patients making advance directives regarding their health care.

Barbara J. Blumer, J.D., and Curtis L. Stine, J.D.

With the establishment of the durable power of attorney for health care effective August 1, 1993, Minnesota now provides four mechanisms by which consumers can record, in advance, their wishes regarding health care to be provided to them in the event they lose their decision-making ability. Minnesota recognizes the fundamental principle that the individual capable of giving informed consent has the right to control health care decisions affecting his or her body. Advance directives provide consumers with tools to direct health care decisions to be made when decision-making capacity is lost due to illness or injury. This article compares and contrasts four Minnesota advance directives, outlines drafting considerations for the new Durable Power of Attorney for Health Care, and offers a proposed form.

Patients will be inquiring about advance directives as community education efforts highlight their usefulness. The federal Patient Self-Determination Act of 1990 requires all Medicare/Medicaid-certified health care facilities (all hospitals and most nursing homes and home care agencies) to provide all patients with information on advance directives and to conduct community education on advance directives.

Advance Directives Options

The four advance directives now recognized by Minnesota statutes are the Nomination of Guardian or Conservator; the Living Will;[1] the Durable Power of Attorney for Health Care—otherwise referred to by its more common name of Health Care Power of Attorney (HCPOA); and the Mental Health Treatment Declaration. Each of these serves a distinct function, although there is some overlap. These instruments are distinguished below.

Nomination of Guardian or Conservator

An individual anticipating the eventual need for a court-appointed guardian or conservator can, while capable, nominate a person or persons to be considered by the court should the need arise. This mechanism, provided for by Minn. Stat. §525.544, can be used to designate a person who may not normally be considered carefully by the court. It is also suitable to indicate a preference among several potential guardians or conservators, for example, from among a large family. The need for a guardian or conservator for health care purposes most often arises when controversial decisions need to be made. In these circumstances, the cost and paperwork burden of establishing a guardianship are far outweighed by the comfort of having the guardian's legal authority clearly established in advance.

An individual with limited interest in advance health care planning can nominate a guardian or conservator through a separate document. However, if the individual executes a living will and/or HCPOA, the proxy or agent appointed in those documents will be automatically nominated as guardian or conservator, unless the individual expressly states otherwise.

Living Will

The Minnesota Living Will Act, Minn. Stat. chap. 145B, was enacted in 1989 and has been amended slightly each year since then.

A living will allows an individual, while capable, to give specific written instructions to health care providers about health care decisions to be made when the individual can no longer make them. An individual may also appoint a proxy (agent) to act in accordance with the instructions in the living will. A proxy is automatically nominated as guardian or conservator under Minn. Stat. §525.544 should one become necessary.

A living will is effective only when the individual is determined to be in a terminal condition.[2] This requirement significantly limits the usefulness of a living will, because it cannot be used to give instructions or appoint an agent to handle temporary or nonterminal medical situations. By contrast, the new HCPOA is effective for nonterminal conditions. Notwithstanding this limitation, a living will is particularly useful if there is no person to be appointed as a proxy or agent or if an individual wishes to limit the effectiveness of his or her instructions and the authority

Health Care Power of Attorney

I appoint __Agent 1__ as my agent (my attorney in fact) to make any health care decision for me when, in the judgment of my attending physician, I am unable to make or communicate the decision myself and when my agent consents to make or communicate the decision on my behalf. If __Agent 1__ is unable, unavailable, or unwilling to serve as agent, I appoint __Agent 2__ as my alternative agent with all powers and responsibilities otherwise conferred on my agent.

My agent has the power to make any health care decision for me, including ❐/not including ❐ (*select one*) decisions relating to the intrusive mental health treatment as defined in Minn. Stat. §253.B.03, subd.6b(1). This power includes the power to give consent, to refuse consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat my physical or mental condition, including giving me food or water by artificial means. My agent has the power, where consistent with the laws of this state, to make a health care decision to withhold or stop health care necessary to keep me alive. It is my intention that my agent has a personal obligation to me to make health care decisions for me consistent with my expressed wishes. I understand, however, that my agent has no legal duty to act.

My agent and any alternative agents have consented to act as my agent when it becomes necessary. My agent and any alternative agents have been notified that they are ❐/are not ❐ (*select one*) nominated as guardian or conservator for me should such proceedings be initiated.

My agent must act consistently with my desires as stated in this document or as otherwise made known by me to my agent. I specifically instruct my agent as follows:

My agent has the same right as I would have to receive, review, and obtain copies of my medical records and to consent to disclosure of those records, with the following limitations: No limitations ❐/Limitations specified as follows:

If my agent is my spouse or registered domestic partner, the commencement of proceedings for dissolution, annulment, or termination of my marriage or actual dissolution, annulment, or termination of my marriage or registered domestic partnership shall ❐/shall not ❐ (*select one*) revoke the appointment of my spouse or registered domestic partner as my agent.

Agent	Alternative Agent
Name	Name
Address	Address
Telephone(s)	Telephone(s)
Relationship (if any)	Relationship (if any)

In Witness Whereof, I hereunto signed my name this _____ day of _____, 199____.

_____
Signature of Principal

STATE OF MINNESOTA
COUNTY OF_____

The foregoing instrument was signed or acknowledged before me this _____ day of _____ 199____, by the principal therein. I am not the agent or alternative agent in the foregoing instrument.

_____
Notary Public

or

I certify that I am at least 18 years of age and that in my presence on the date appearing above the principal signed or acknowledged the signing of this instrument. I am not named as agent or alternative agent in the instrument. If I am a health care provider or an employee of a health care provider providing direct care to the principal on the date appearing above, I have so noted below.

_____	_____
Witness Signature	Witness Signature
Address	Address
Health Care Provider?	Health Care Provider?
Yes ❐ No ❐	Yes ❐ No ❐

of the proxy to situations of terminal illness.

Health Care Power of Attorney

Execution of an HCPOA under new Minn. Stat. chap. 145C designates an agent to make a health care decision at any time the principal is unable to make or express a health care decision. This is in contrast to the living will, which empowers the agent to act only when the principal is in a terminal condition. The scope of the agent's authority can be, and is anticipated in most cases to be, very broad;[3] but a principal can tailor the authority given to the agent in almost any manner. While an HCPOA can be drafted without any instructions to the agent, or without the expression of preferences and values, it is best to give the agent as much written guidance as possible. The agent is obligated to make health care decisions according to the expressed wishes of the principal, whether written in the HCPOA or expressed to the agent in another manner.[4]

If instructions and expressions of preferences are included in an HCPOA, it can entirely eliminate the need for a living will with a proxy appointment. Separate instructions can be given for terminal and nonterminal conditions, if the principal so desires.

An HCPOA can also be used in conjunction with a living will. The living will would be drafted to apply to terminal conditions and the HCPOA to apply in all other cases. If that approach is taken, considerable care should be given to ensure consistency between the two documents.

Revocation of an HCPOA requires more formality than is currently required for revocation of a living will. This is in keeping with the rationale that a legal document solemnly executed by a competent person should be revocable with commensurate solemnity but reasonable flexibility. While a living will may be revoked "at any time and in any manner ... without regard to the declarant's physical or mental condition,"[5] an HCPOA may be revoked only by the means set forth in the statute. These include an oral revocation witnessed by two persons who do not have to be present at the same time.[6]

A provision of the HCPOA law that has generated considerable comment is Minn. Stat. §145C.15, dealing with the duties of health care providers regarding life-sustaining health care. It has been suggested that the statutory language may permit an agent to demand health care and impose a duty on health care providers to provide such care without regard to its efficacy. This section was intended to establish only that the appointment of an agent does not diminish the authority patients have concerning their health care at critical times. The testimony at the legislative hearings makes clear that this section was intended to place the agent in the same position as a competent patient concerning requests to health care providers for life-sustaining care. All decisions about care to be provided are subject to the currently prevailing standard of "reasonable medical judgment." The language was not intended to give the agent any greater or lesser authority over health care providers than a competent patient would have. Nor was it intended to empower the agent to compel health care providers, over their objections, to provide health care that reasonable medical judgment would deem futile. The ongoing debate about whether health care providers, confronted with the request of a patient or the patient's family or agent, are obliged to provide health care that reasonable medical judgment would deem "futile," was not intended to be resolved in this statute.

Mental Health Treatment Directive

Minn. Stat. §253B.03 permits individuals contemplating the need for psychiatric medication and/or electroconvulsive therapy in times of incapacity to write instructions to their health care providers about their preferences and/or appoint proxies to make decisions for them. This advance directive is thus very similar to a living will but does not require a terminal condition to be effective. Health care providers must still obtain the individual's informed consent for such treatments as long as the individual is able to give it. Given the special focus of this directive, it would most often be drafted and executed separately from a living will or HCPOA. However, the HCPOA statute provides that an HCPOA can give the agent authority over psychiatric medications and electroconvulsive therapy, in addition to other health care decisions, if the HCPOA makes special provision to that effect.[7] There is no form suggested in the statute for a mental health directive, but forms are available from mental health advocacy groups.

Drafting and Execution

The HCPOA statute sets a suggested form for an HCPOA that "may, but need not be" used.[8] This approach differs from that for the Statutory Short Form Power of Attorney for property matters (which requires the form to be duplicated exactly)[9] and from that for the living will (which requires that a living will be "substantially in the form" set forth).[10] Nevertheless, the statutorily suggested form serves as a useful guide to drafting a valid HCPOA. A form that we propose, incorporating several optional provisions, appears on the facing page.

Although the statute does not require it, in our judgment the principal should always appoint an alternative agent if one is available. That optional provision[11] is incorporated in the proposed form. Under common agency principles, an agent has no legal duty to act, even if the agent has previously consented to the agency appointment. During the legislative hearings, there was much discussion about the real possibility that the primary agent would be unable to act due to unavailability (personal illness, vacations, business trips, etc.) or simply because the health care decisions facing the agent are too difficult, either technically or emotionally. In order to be better assured that there will be an agent available and willing to act when necessary, the principal should attempt to appoint an alternative agent or agents.

Related to this issue are the unusual provisions in the statute that state that the agent owes a personal

obligation, but not a legal duty, to the principal to act when necessary.[12] These provisions recognize that an agent may legitimately be unable to make health care decisions, even after having previously agreed in good faith to do so, and that no legal sanctions should be imposed upon the agent for failing to act. However, they also reflect the depth of the principal's reliance on the agent's assurance, communicated through the agent's consent to be appointed, that the agent will act in the principal's hour of need. Both principals and agents should carefully consider the personal commitments being asked for and made in establishing this relationship.

Written instructions on health care issues of greatest importance to the principal should be included in the body of the HCPOA, as illustrated in the proposed form. This is optional,[13] but the advantages of written instructions to the principal, the agent, family members, and health care providers are many.

Putting at least the major instructions in writing will assist any alternative agent called upon to act and, in controversial cases, will assist all parties in providing written evidence of the principal's wishes. These instructions will likely be similar to those currently found in living wills. Whatever form these written instructions take, the principal and the agent should discuss the principal's wishes when the power is executed and periodically thereafter. The agent is bound to act in accordance with the principal's wishes, however communicated.[14]

The proposed form includes four checkoff options to reflect four statutorily recognized options. The first checkoff allows the principal to give the agent authority to make the mental health treatment decision under Minn. Stat. §253B.03, discussed above. Such authority must be specifically delegated in an HCPOA to be effective.[15] The HCPOA is presumed not to apply to such decisions on the theory that this power should be granted only upon special consideration.

The second checkoff allows the principal to address, and choose to eliminate,[16] the statutory assumption that the person nominated as agent would also be nominated by the principal as a guardian or conservator.[17]

The third checkoff allows the principal to restrict the agent's broad statutory access of medical records[18] with any limitations the principal may choose to impose.[19] Limitations are not likely to be imposed frequently; they would limit the agent's access to information necessary for good decision making.

The fourth checkoff permits the principal to override the statutory presumption that dissolution of a marriage or registered domestic partnership also revokes an HCPOA.[20] Since dissolution of marriage does not in every case mean termination of a meaningful personal relationship, particularly for individuals with long-term disabilities requiring Medical Assistance, the statute allows a principal to specify that a spouse or partner may continue as agent.

The HCPOA statute mandates three substantive execution requirements.[21] The HCPOA must be signed by the principal or in the principal's name by another acting in the principal's presence and by the principal's direction. It must also contain the date of execution (which aids in determining priority among inconsistent documents) and must either be witnessed by two witnesses or acknowledged before a notary. The notary may not be an agent appointed in the HCPOA, but may be a health care provider or employee of a health care provider providing care to the principal. The agent(s) appointed in the HCPOA may not be a witness, and only one of the two witnesses may be a health care provider or employee of a health care provider providing care to the principal.

The proposed form contains language so that compliance with the witnessing and notary requirements is evident on the face of the HCPOA. It should be noted that the HCPOA execution provisions differ from those for the living will.[22]

Conclusion

The most frequently asked question during the 1993 legislative deliberations on the new HCPOA statute was why a new advance directive was needed and why a separate statute was being proposed. Several other states have consolidated their health care advance directive provisions into one act, which greatly simplifies the inherently strained process involved in contemplating incapacity and death. We look forward to the day when consolidation of the varied Minnesota provisions will be politically feasible, so that one form with one set of execution provisions and one set of revocation standards will be available to patients and health care providers alike. Until that time, the HCPOA fills the major gap that previously existed in Minnesota law by providing individuals clear authority to appoint an agent to make decisions when they are unable to do so but are not considered terminally ill. MM

Barbara Blumer, an attorney practicing in Eagan, was a chief author of the HCPOA statute for the Minnesota State Bar Association's Subcommittee on Durable Power of Attorney for Health Care. Curtis Stine is professor of law at William Mitchell College of Law. He chaired the MSBA's Subcommittee on Durable Power of Attorney for Health Care of the Probate and Trust Law Section.

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9. Minn. Stat. §523.23.
10. Minn. Stat. §145B.04.
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12. Minn. Stat. §145C.07, subd.3 and §145C.05, subd.1.
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16. Minn. Stat. §145C.05, subd.2(4).
17. Minn. Stat. §145C.07, subd.2.
18. Minn. Stat. §145C.08.
19. Minn. Stat. §145C.05, subd.2(3).
20. Minn. Stat. §145C.09, subd.2.
21. Minn. Stat. §145C.03.

Linking Practice Parameters with Outcomes Data

State Should Look to MCCAP

C. Randall Nelms Jr., M.D.

Health care reform is now a priority in Minnesota and the nation. Practice parameters and data collection are two mechanisms MinnesotaCare will use to contain costs and attempt to improve outcomes. Health care leaders hope that by linking clinical practice parameters with outcomes research, the effectiveness and efficiency of health care services will improve. As part of its reform efforts, the state has established a Data Institute, a Data Analysis Unit, and a Practice Parameter Advisory Committee, all under MinnesotaCare.

I hope the state will not overlook one project that already conducts outcomes research and develops practice guidelines. Since its start in 1989, the Minnesota Clinical Comparison and Assessment Project (MCCAP), implemented under the auspices of the Healthcare Education and Research Foundation (HERF), has been working to improve the appropriateness, efficiency, and effectiveness of health care delivery in Minnesota by linking clinical practice guidelines with outcomes data and reporting the information to clinicians. MCCAP is out in front in terms of applying total quality management methods to clinical guideline efforts, and it provides the organizational structure necessary to unify the duplicative, proprietary, and fragmented quality improvement programs initiated by health care institutions, insurance companies, and others. Cooperation between MCCAP and MinnesotaCare would be in the state's best interest.

MCCAP encourages physicians to take a proactive leadership role in the development of practice parameters. It is co-sponsored by the Minnesota Medical Association, Hennepin and Ramsey county medical societies, the Metropolitan Healthcare Council (formerly the Council of Hospital Corporations), the Minnesota Hospital Association, and the University of Minnesota School of Public Health. When MCCAP was initiated, clinical leaders were recruited to participate in the guideline panels. Clinicians want to make sure that the outcomes measured are appropriate and that the data accurately reflect important aspects of care.

"MCCAP is out in front in terms of applying total quality management methods to clinical guideline efforts."

Once guidelines are developed, data are collected and analyzed and then presented to clinicians, allowing them to compare treatment methods and patient outcomes with those of their colleagues and with the guideline recommendations. The data then enable the clinicians to evaluate their practice styles and patient outcomes and, if appropriate, change treatment methods. The aggregate outcomes information is used to revise and strengthen the original guidelines. After this, another cycle of data collection and feedback begins. After each cycle, the guidelines are improved with outcomes-based data. The goal is to evaluate and improve health care in Minnesota.

According to HERF officials, MCCAP has become the largest consortium of hospitals collecting data in the country, encompassing 53 Minnesota hospitals representing approximately 60 percent of the licensed beds in the state. It has collected both inpatient and post-discharge patient outcomes information on 3,500 elective cholecystectomies, 2,500 total hip replacements, and 2,700 cesarean births. Many local clinicians were skeptical about the usefulness of patient-generated outcomes data, but now this information appears to be not only interesting, but also quite useful to clinicians and hospital staff.

However, much work remains. The gap between nationally developed guidelines and outcomes research, as well as their local application within Minnesota health care settings, must be bridged, and data acquisition and presentation methods must be continuously improved and automated.

What have we learned thus far from our experience collecting data? We know that the costs and amount of work needed for outcomes evaluation are often underestimated. Guidelines can rarely be based only on limited literature published by a few "experts," and clinical experiences must be used as the basis for many guideline recommendations. The process of guideline development must be carefully undertaken since many decisions about the process itself affect the final guidelines. MM

LETTERS

(continued from page 3)

Malpractice suits certainly can be brought against physicians who practice flawless medicine, and they can bring on a great deal of emotional suffering. Articles such as this regularly appear in medical journals. However, I feel another important issue is being sidestepped.

How would the author have felt if, in retrospect, she had committed an error? Perhaps not a flagrant one or one that colleagues would even acknowledge, but clear enough to her? What if she had not put the physical and lab findings together quickly enough to avert a bad outcome?

Physician error is something that only a few courageous physicians have written about publicly (Hilfiker D, N Engl J Med 1984; 310(2):118-22). Yet, over the course of a career, all of us will make such errors. This is despite the fact that physicians tend to be compulsive overachievers who are trying for a perfect outcome with every patient encounter. The threat of malpractice, PRO sanctions, or discipline by the Board of Medical Practice is only a part of the emotional burden that we must bear as physicians. We must also learn to accept that we are human and that we will make mistakes.

I agree that the National Practitioner Data Bank is a poorly conceived way to protect the public against "bad doctors." It is a symptom of a medical system that expects its physicians to be perfect, every minute of every day. In my opinion, this attitude is responsible for a great deal of the dissatisfaction so many physicians express about their chosen profession.

Establishing a support group to help physicians going through a malpractice suit is a good idea. However, this group, or a similar one, should be open to physicians trying to deal with the anguish of real (or perceived) physician error.

Carl Melling, M.D.
Melrose Clinic
Melrose, Minnesota

Has BMP Gone Too Far?

I sympathize with the author of the November Perspectives article on malpractice. I wonder why the Board of Medical Practice has to pass judgment on physicians who have been sued. Isn't the judgment of the legal system enough? Isn't the trauma of a legal action enough without superimposing the trauma of a medical board action?

Physicians are required to report malpractice actions to the board at the time of license renewal. I try to see the reason for this. I suppose it gives the board a handle on flagrant physician misconduct as reflected in lawsuits. When a physician has done a good job for 13 years (as the author of the article states she has) and is required to answer to the board for a single malpractice action, something has gone too far. Even though the board may dismiss the complaint, the interminable wait for judgment is unconscionable. It should not take two years for the board to take action. It is not enough for the board to say it is overburdened with other problems, such as improper narcotic prescribing, sexual harassment charges, professional misconduct, drug addiction, and improper medical care. The board should have some process to weed significant problems from cases that are routinely reported and need no action. The review process should be accelerated to eliminate the wait the author describes. Apparently, no one in the administrative section of the Minnesota Board of Medical Practice is willing to take a stand for speedier review.

The board has assumed a judgmental role and has become a specter overhanging every physician's medical practice. It has usurped the review process, which every physician on a hospital staff has willingly accepted as a part of his or her practice of medicine.

The author's ideas about support groups for physicians being sued are good. It can be very lonely when one's professional competence is being unfairly questioned. The defendant is embarrassed and does not want to be branded as incompetent by communities or colleagues. As a result, the pain becomes internally directed.

Kenneth Covey, M.D.
Retired orthopedic physician
Moorhead, Minnesota

BMP Just Following the Law

I read with interest the article "Malpractice Nightmare" by an anonymous physician. I sympathize with her pain and have compassion and concern regarding the medical paralysis she suffered as a result of her malpractice settlement. However, it is unfortunate the doctor considers the Board of Medical Practice review of her malpractice settlement as a "formal inquisition"—nothing could be further from the truth. By law, all medical malpractice actions must be reported to the board, which then evaluates the reports to determine whether they include infractions of the Medical Practice Act and/or threats to patients' safety. Frankly, in my experience, those malpractice actions have not been a meaningful source of problems for the board to evaluate. Faced with overwhelming numbers of other complaints, the board prioritizes, and as a result, "less-threatening" problems take longer to resolve. Nonetheless, it is valid to criticize the delay, as it does leave physicians "hanging-in-the-wind" far too long. Once evaluated by the Board of Medical Practice, malpractice actions, which are reviewed by peers rather than a lay jury, receive a much more meaningful and understanding reading—rarely resulting in formal discipline.

The article's author finally lists those items that could be helpful for physicians facing a malpractice suit. She particularly stresses the need for multifaceted support, including a system for those

physicians overwhelmed by a medical malpractice action. This suggestion is to be commended and supported. In response to her second main initiative, for many reasons I personally do not foresee meaningful tort reform or abolition of the National Practitioner Data Bank; they both will remain unwanted baggage on the stormy trip into health system reform.

Melvin E. Sigel, M.D., F.A.C.S.
Former member
Minnesota Board of Medical Practice
Immediate past president
Federation of State Medical Boards of the United States
Otolaryngologist/Facial plastic surgeon
Minneapolis Ear, Nose & Throat Clinic, P.A.
Minneapolis, Minnesota

Not a Habit We Want to Get Into

I was pleased to see the recent article on compulsive gambling ("When Luck Runs Out—Compulsive Gambling: Bad Habit or Serious Illness," October 1993). I was disappointed to see that the title was taken in part from a book written by Robert Custer, M.D., and Harry Milt. Whereas Dr. Custer was cited in the article, he received no credit for his book "When Luck Runs Out" (published in 1985, Facts on File Publications). This book is an excellent resource both for physicians and families of compulsive gamblers. Dr. Custer also made several trips to Minnesota in the early 1980s to help establish training programs for compulsive gamblers.

Basil C. LeBlanc, M.D.
Family physician
Midwest Occupational Medicine
St. Cloud, Minnesota

Lyme Disease Battle Leaving People to Suffer

The battle over Lyme disease has been bifurcated. One fraction posits the irrelevance of long-term treatment; the other promotes its necessity. The former asserts if the patient is not cured with short-term treatment, the malady is not Lyme disease. Concurrently, this group alleges some Lyme disease patients may never fully recover. Applied logic does not allow the simultaneous holding of these two mutually exclusive positions. One opinion must be false; both may be. Moreover, they are, indeed, merely opinions. Hippocrates stated, "[T]here are in fact two things, science and opinion; the former begets knowledge, the latter ignorance."

Lyme disease has presented a quagmire of issues, none of which has been resolved. The current objective should not be to divide arbitrarily, but to conquer the disease through lucid rumination and scientific study. To this end, it is again instructive to look to Hippocrates. He is oft misquoted as stating, "First do no harm." The actual quote does not provide this comfortable escape veiled in pseudo-altruistic nonfeasance. Rather, he taught, "[A]s to diseases make a habit of two things—to help, or at least, to do no harm." Thus, the charge is to be proactive and provide assistance. Alternatively, as a last resort, avoid harm. It should be noted, however, that leaving people to suffer, based merely on opinion or sheer ignorance is, according to Hippocrates, a great harm.

Steven D. Reske, Esq.
A former editor of The American Journal of Law and Medicine
Author and attorney
Minneapolis, MN

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Announcements

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MEDPAC Workshop Scheduled in February

MEDPAC and the AMA are planning a half-day political education workshop for MMA members who want to learn how to play a more effective part in the legislative process. The workshop is scheduled for Saturday, February 19, from 8 a.m. to 1 p.m. A continental breakfast and lunch will be provided. Political experts, including Michael Dunne, a Washington, D.C., political consultant who works closely with the AMA, will conduct the workshop. The MEDPAC workshop is free, but space is limited, so please respond as quickly as possible. A brochure with the exact time, location, and agenda will be mailed out soon, but you may reserve your place now by calling Wendy O'Donnell or Dave Renner at the MMA, 612/378-1875 or 800/999-1875.

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Update 1994 CPT/ICD-9

The MMA will present "Update 1994 CPT/ICD-9," an annual conference on coding changes, January 18, 1994, at the Sheraton Inn Midway in St. Paul. The conference will address the major changes to CPT and ICD-9 for 1994, including an overview of physician payment reform issues, changes to evaluation and management coding and documentation, changes to modifiers, changes to general surgical and to major surgical and ICD-9-CM. This program has been approved by the American Health Information Management Association for three continuing education hours. The program, conducted by the Profile Group, will be presented twice. Session I is scheduled from 8:30 a.m. to 12 noon, and session II from 1 p.m. to 4 p.m. The registration fee is $85. To register, contact Vicki Westling at 612/378-1875 or 800/999-1875.

The Monitor

News For Minnesota Physicians

MMA Presents ISN Position Paper to State

On November 30, Timothy J. Crimmins, M.D., presented the "MMA Integrated Service Network Position Paper" to the Minnesota Health Care Commission. In this document, the MMA responds to ISN provisions in the Minnesota Department of Health's draft plan for the regulated all payer system (RAPS) and the integrated service networks (ISNs). The MMA forwarded the position paper to the Minnesota Department of Health. The MDH will revise its draft in light of comments it receives from the MMA and others before putting the plan into legislative language and submitting it to the 1994 Legislature.

The MMA positions on ISNs were approved at a November 23 meeting of the MMA ISN Subcommittee, the MMA MinnesotaCare Task Force, and the MMA Board of Trustees and in later discussions of the MMA Executive Committee.

Highlights of the MMA position are summarized below.

Approach to ISNs

The MMA will continue to consider the ISN concept as innovative and experimental in nature. "ISNs are still unproven," said Andrew J.K. Smith, M.D., MMA president elect, at the November 23 meeting. "We can't give our seal of approval until we know what we're dealing with."

The MMA supports the MDH proposal that requires entities that currently operate as HMOs and nonprofit health plans to operate only as ISNs under ISN law, and all-payer insurers to operate only as traditional indemnity plans. The MMA supports the creation of a truly reformed system.

Insurance Reform

The MMA reaffirms its support for universal access to health care and supports the MDH plan to extend insurance reforms to the small business market as a step toward that goal. The proposed insurance reforms don't go far enough, however, toward achieving universal access.

"The major flaw in the plan is that there is no mandate for health care insurance," said Richard B. Tompkins, M.D. Agreeing that the MDH plan fails to solve the problem of health care for the uninsured, Lyle Munneke, M.D., said that, "farmers who are having a hard time will buy seed and other products before they will buy insurance." The MMA supports further insurance reforms, such as elimination of waiting periods and pre-existing condition limitations or exclusions, as well as elimination of any other barriers to coverage based on health status. The MMA notes that these reforms will only work in a system that requires everyone to have coverage.

Level Field for ISNs and RAPS

The MMA strongly opposes a "tilt" toward either ISNs or RAPS. The market should be allowed to work. Patient choice, community need, and market forces should be allowed to determine the most effective delivery system. The MMA would object to

ISN continued on page 38

MINNESOTACARE NEWS

New Balance Billing Limits Take Effect

Beginning January 1, 1994, "non-participating" health care providers in the Medicare program may not charge a Medicare beneficiary who is a Minnesota resident more than 110 percent of the Medicare-approved amount for any Medicare-covered service. Beginning January 1, 1995, providers will have to limit charges to 105 percent of the non-participating approved charges, and starting January 1, 1996, balance billing to Minnesota residents will be banned.

These new limits, which are the result of the 1992 MinnesotaCare legislation, are lower than the federal limiting charge of 115 percent. This could give rise to confusion. The two Medicare carriers in Minnesota, Travelers and Blue Cross and Blue Shield, administer the federal Medicare program, but not the state limits. Therefore, they will continue to refer to the federal 115 percent limiting charge rather than to Minnesota's 110 percent limit.

The Minnesota Department of Health expects providers to voluntarily comply with the law. MDH staff have indicated that if they become aware of violations, they plan to enforce the limit.

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Data Collection Moves Forward

The first round of data collection is drawing to a close. Last year, the state asked most large clinics to collect revenue and expenditure data from July 1, 1993, to December 31, 1993. Now the state has mailed out data collection surveys asking for that information. The surveys should be completed by February 15, 1994, and returned to the Minnesota Department of Health. Physician clinics that are registered with Medical Assistance and whose MA number begins with "21" must complete the survey. If you didn't receive a survey and should have, call Jerry Dalnes at MDH, 612/282-6312.

The state plans to collect data from other providers in the near future. Prepare now by setting up a system to monitor your revenues by payer type. You should be able to break out such payers as Medicare, Medical Assistance, and commercial insurance, as well as out-of-pocket and uncompensated care.

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You are Invited to Comment on Technology

The Health Technology Advisory Committee (HTAC), an advisory committee to the Minnesota Health Care Commission, is conducting its first technology evaluation. Its preliminary technology evaluation report on tissue plasminogen activator (tPA) for acute myocardial infarction will be completed by the end of January. HTAC encourages specialty societies and individual physicians to comment.

The MMA, through its Interspecialty Council, is working with HTAC staff to provide input from the various specialty societies. The Interspecialty Council wants to make sure that physicians who will be affected by these evaluations have the opportunity to provide information. "HTAC's evaluations could affect the practice of us all. It is imperative that physicians be involved in the process," said Donald Asp, M.D., chair of the Interspecialty Council.

The 17-member HTAC evaluates the use and application of specific technologies in terms of safety, health outcomes, clinical effectiveness, cost-effectiveness, and other factors. Although its evaluations are not rules, HTAC's reports are of critical importance. They may be used by the commissioner of health to review major expenditures; by ISNs or RAPS to make decisions about coverage, contracting, purchasing, and reimbursement; by the commissioner and other organizations to develop practice parameters; as well as by health care providers, consumers, and medical device manufacturers.

After HTAC's preliminary technology evaluation report is published in the *State Register,* the public will have 30 days to submit written comments. State law requires HTAC to include a summary of these comments in its report. The final opportunity to provide input will be during open testimony before the Minnesota Health Care Commission.

The next three technologies that HTAC will evaluate are 1) autologous bone marrow transplant for solid tumors and bone marrow cancers, 2) prostatic specific antigen for prostate cancer screening, and 3) magnetic resonance imaging for diagnosis of headache.

Specialty societies, other groups, and individual physicians who have information pertinent to the evaluation of these technologies are encouraged to contact Mary Fahey, HTAC staff, at 612/282-6355. Information may be mailed to her at P.O. Box 64975, St. Paul, MN 55164-0975.

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MinnesotaCare Interactive Voice Response

Providers are responsible for verifying the eligibility of MinnesotaCare cardholders. To make verification easier, the Minnesota Department of Human Services offers a 24-hour, toll-free Interactive Voice Response system. For access to information about MinnesotaCare eligibility, call

MINNESOTACARE NEWS

282-2599 in the Twin Cities metropolitan area, or call toll free 800/657-3985.

MMA Joins Tax Pass-Through Effort

The MMA is participating in a MinnesotaCare 2 Percent Tax Pass-Through Technical Advisory Group (TAG) to the Minnesota Administrative Uniformity Committee (AUC). The AUC is a statewide, voluntary group representing public and private payers, hospitals, physicians, and other health care providers. Its purpose is to develop recommendations regarding uniform billing and other administrative policies and procedures that will reduce costs and improve quality, as well as to implement strategies to achieve these improvements. The MMA has participated in AUC discussions to achieve standardization and uniformity in claims submission via the HCFA 1500 and UB82/92 claim forms. Participants on the TAG include a representative from the Minnesota Medical Group Management Association, who chairs the group, and representatives from Preferred One, the Insurance Federation, Mayo Clinic, Medica, HealthPartners, and Blue Cross and Blue Shield. The group hopes to develop some strategies for payers and providers to manage the pass-through.

Additional information on how to handle the pass-through provision can be obtained from the payers. Contact the Department of Revenue at 612/297-1882 or 800/657-3618 if you have MinnesotaCare tax questions.

LEGAL ISSUES

Surcharge Class Action Suffers Setback

On November 29, Minnesota District Judge Harvey Ginsberg dismissed the class action on behalf of physicians whose medical licenses were issued or renewed between April 1, 1992, and September 30, 1992, and who were assessed and paid a $400 surcharge on their medical licenses. In one of its arguments, the class action contended that it was illegal for the state to require these physicians to pay the surcharge because their medical licenses were issued or renewed before the law became effective on October 1, 1992. The defendants in the case were the state of Minnesota, the Minnesota Board of Medical Practice, and the Minnesota Department of Human Services. The plaintiffs sought a refund of the $400 surcharge for all class members.

The MMA helped to coordinate the efforts of the physicians in the class action, which included more than 5,000 physicians. In April, physicians who were eligible to participate were notified that they would be part of the class action unless they chose to opt out. The vast majority of eligible physicians chose to remain part of the class.

While the case was pending, the 1993 Minnesota Legislature passed an amendment "clarifying" its intention that the surcharge be assessed against the plaintiffs in 1992. The amendment also stated that the law applied to cases pending.

Referring to the 1993 amendment, Judge Ginsberg ruled that the intent of the Legislature was clear. He found that there was not a "retroactive operation of the Statute," as the class action contended, but that the "surcharge is merely collected well in advance of license renewal." He based his decision on the fact that failure to pay the surcharge didn't affect the physicians' right to practice medicine for the duration of the license year, but rather denied their right to renew their licenses the following year (1993-94).

Plaintiffs argued that whether the surcharge affects an existing license or the ability to renew a license is irrelevant. Their ability to practice medicine is at some point impaired. They will appeal the decision. The MMA will support their suit.

Physician Error May Lead to Imprisonment

A New York lawsuit has attracted national notice because it is the first to criminalize an alleged error in physician judgment. Gerald Einaugler, M.D, faces jail time for failing to immediately hospitalize a nursing home patient after he ordered she be fed through a dialysis catheter that he had mistaken for a feeding tube. The patient subsequently died. There was no autopsy to determine cause of death in this 78-year-old woman who suffered from end-stage renal disease, cardiovascular disease, retinopathy that left her nearly blind, diabetes, and organic brain syndrome.

In June 1992, Einaugler was indicted for two misdemeanors, reckless endangerment in the second degree, and neglecting the patient, a violation of the Public Health Law. The medical examiner testified for the prosecution that death was due to peritonitis following feeding though the dialysis catheter. The former

LEGAL ISSUES

chief medical examiner for New York City testified for the defense that he believed the patient died of progressive natural causes. A jury convicted Einaugler, not because of his mistaken order, but because he inappropriately delayed hospitalization for more than 10 hours.

Einaugler was sentenced to weekends in jail for one year at Rikers Island. He is appealing his conviction. At his request, the Medical Society of the State of New York filed an amicus curiae brief, arguing that Einaugler should not be charged with criminal liability because he had a reasonable basis to believe there was no immediate need for hospitalization. The Society of Internal Medicine in New York and the Kings County Medical Society are also filing amici curiae on his behalf.

In a letter sent to the MMA, Einaugler charges that the government is trying to criminalize medicine. He says that "a nurse destroyed the cap of the (Tenckoff) catheter, all the nurses who testified received immunity, the x-ray of the abdomen on admission showed no peritonitis, nobody from the renal department saw the patient that entire day, and dialysis was started 15 hours after admission (the following day)."

Border State Suit Will Be Appealed

After the legal challenge to Minnesota's 2 percent tax on health care services provided outside the state was dismissed November 8, the AMA and the border state associations agreed to appeal the lower court decision. The associations also want an exemption to the tax anti-injunction statute that would allow them to bring constitutional challenges. The reason for dismissal of the border state lawsuit was an anti-injunction statute prohibiting lawsuits to restrain the assessment or collection of taxes. The border hospital associations have now filed a lawsuit challenging the tax.

Kentucky Overthrows Provider Tax

The Kentucky Medical Association recently led a coalition of plaintiffs in a successful challenge to that state's 2 percent tax on physicians' gross revenues. On November 23, 1993, a circuit court judge ruled that Kentucky's provider tax violated a state constitutional law prohibiting special legislation favoring or disfavoring particular groups. Like Minnesota's medical license surcharge, this tax was designed to maximize the federal funds the state received for its Medicaid program. The tax applied to the gross revenues of all physicians practicing medicine in Kentucky and provided an indirect benefit in the form of higher reimbursement to the 60 percent of physicians participating in the Medicaid program. The court struck down the tax and permanently enjoined the state from collecting it.

Because of differences in constitutional language, however, this lawsuit may have no bearing in Minnesota. MMA legal counsel is analyzing the case and comparing the constitutions of Kentucky and Minnesota.

MEDPAC

New MEDPAC Officers

The new officers of the MEDPAC Board of Trustees elected at the MEDPAC annual meeting in September took office January 1, 1994. John Dowdle, M.D., is the chair, and David Byer, M.D., the secretary-treasurer. The other members of the MEDPAC Executive Committee are William Chandler, M.D., immediate past chair, Gayle Whitesell, and Joanne Mueller.

MEDPAC Invites You to Join the Board

MEDPAC is recruiting new members to serve on the MEDPAC Board of Directors. This recruitment effort is part of a strategy to expand and restructure the MEDPAC Board so there will be a member in each senate district. The MEDPAC Board administers the PAC, endorses candidates, and allocates contributions to candidates. Board members also serve as key contacts with legislators. If you are interested in serving on the MEDPAC Board, contact Wendy O'Donnell or Dave Renner at the MMA, 612/378-1875, or 800/999-1875.

ANNOUNCEMENTS

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NEW WORKERS' COMP RULES IN EFFECT

The permanent rules relating to Workers' Compensation Managed Care and Independent Medical Examination Fees have been adopted and filed with the Minnesota secretary of state. The rules appeared in the November 22, 1993, edition of the *State Register* and became effective December 1, 1993. You may obtain copies of the rules from the Minnesota Bookstore by calling 612/297-3000 or 800/657-3757.

The permanent rule for the new Workers' Compensation fee schedule became effective December 20, 1993. The recently adopted rule appeared in the December 13, 1993, edition of the *State Register* and is now available from the Minnesota Bookstore. To order copies of the new fee schedule, call 612/297-3000 or 800/657-3757.

For more information about these rules, call Molly Sigel at the MMA, 612/378-1875 or 800/999-1875.

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WELLSTONE PROVIDER FORUM

Sen. Paul Wellstone invites providers to attend a health care provider forum at 7 p.m. January 10 at the Hennepin County Medical Center, Pillsbury Auditorium, in Minneapolis. Workshops will also be scheduled in Duluth and St. Cloud.

MMA Is Successful at the 1993 AMA Annual Meeting

All six MMA resolutions were well received by the AMA House of Delegates at the 1993 AMA Interim Meeting December 5-8 in New Orleans.

State Physician Surcharges for Medicaid Funding

Resolution 207, "State Physician Surcharges for Medicaid Funding," was placed on the consent calendar and adopted. This resolution asks the AMA to seek repeal of the provisions in Section 1902 (a)(2) of Public Law 102-234 that allow states to tax physicians for the purpose of increasing the states' federal funding for Medicaid, and that the AMA support adequate broad-based taxes for the appropriate funding of Medicaid and other government health care programs.

Proposed Excessive Federal Fees for Aviation Medical Examiners

Resolution 209, "Proposed Excessive Federal Fees for Aviation Medical Examiners," was also placed on the consent calendar and adopted. This resolution calls upon the AMA to oppose any regulations requiring aviation medical examiners to attend seminars with excessive registration fees, and to oppose any legislation imposing a fee for serving as an aviation medical examiner for the FAA.

Access to Primary Care Services

Resolution 106, "Access to Primary Care Services," was referred to the AMA Board of Trustees for report back to the House of Delegates at the 1994 Annual Meeting in June. This resolution asks the AMA to support legislative and regulatory initiatives to assure that a patient's access to primary care services provided by a physician is not limited by the physician's specialty or subspecialty designation, but determined by the physician's training and competence. Reference Committee A recommended that this complex issue be referred to the Board so that it could be considered as part of ongoing efforts by the AMA.

Medicare Reimbursement of Office-Based Procedures

In lieu of Resolution 103, "Medicare Reimbursement of Office-Based Procedures," the AMA House adopted a substitute resolution. The AMA will encourage the Health Care Financing Administration to expand the extent and amount of reimbursement for procedures performed in the physician's office and to shift more procedures from the hospital to the office setting, which is more cost-effective. Furthermore, the AMA will seek to have the RBRVS practice expense RVUs reflect the true cost of performing office procedures. The AMA will work with the Health Care Financing Administration to develop consistent regulations to be followed by carriers that include reimbursement for the costs of disposable supplies and surgical tray fees incurred with office-based procedures and surgery.

The original resolution called upon the AMA to work with the Health Care Financing Administration to develop consistent regulations to be followed by the Medicare carriers that include reimbursement for costs of disposable items and surgical tray preparation incurred from office-based procedures and surgery.

Testimony before Reference Committee A revealed that there has been some recent progress on this issue. HCFA has included a number of urology services on the list of services for which a supply payment will be made. The Minnesota delegation was pleased with the language of the substitute resolution.

Non-Routine Waiver for Indigent Patients

Resolution 210, "Non-Routine

AMA continued on page 40

ISN continued from page 33

setting a low conversion factor for RAPS in order to create an incentive for physicians to join ISNs. There should be adequate reimbursement for providers in both systems.

One of the crucial questions facing the state is how to provide a level playing field for ISNs and RAPS. The MDH draft proposes that the state assess all-payer insurers for the value of state regulations that it believes will give them an unfair advantage —regulation of RAPS provider fees and utilization, the ability to offer free choice of providers and freedom from certain ISN requirements. The MMA questions, however, how the state will be able to set a "value" for these regulations. There is a danger that the assessment will create imbalance rather than correct it.

Contract Exclusivity

The MMA proposes language intended to protect physicians from pressures to enter the exclusive arrangements that are permitted by the MDH plan. The MMA recommends that the state prohibit a health care entity from penalizing, or threatening to penalize, a physician for participating in, or endorsing, a competing network or entity. Providers who sign a contract with a health carrier that later forms an ISN should not be bound to participate in that ISN unless the contract explicitly outlines a relationship with a future ISN, or unless there is an opportunity to renegotiate the contract, or by mutual consent of the health carrier and the provider. This provision should not apply to contracts between a health carrier and its salaried employees. If providers claim to have been pressured, coerced, or otherwise unfairly forced to sign a contract that affects their ability to participate or refrain from participating in an ISN that may be formed by the health carrier in the future, the MMA recommends that the commissioner of health review that contract.

Credentialing and Criteria

The MMA agrees with the MDH that ISNs should be allowed to define their own credentialing standards and other criteria for joining their provider networks and that these criteria must be made public.

After careful deliberation, the MMA decided to support the provision that would require an ISN to accept any willing provider who fulfills its criteria and credentialing requirements. The thorny issue of whether ISNs should be required to accept "any willing provider" was raised by the 1993 MMA House of Delegates in Resolution 8, "Feasibility of Any Willing Provider," submitted by the Ramsey County Medical Society and adopted as amended. The MMA resolved to explore the need for, and merits of, pursuing "any willing provider" legislation in Minnesota, including issues of exclusive contracts and selective provider contracts, and report to the MMA Board for possible action during the 1994 legislative session.

The MMA carefully considered the pros and cons of "any willing provider" legislation in preparing the position paper. At the November 23 meeting, Timothy Crimmins, M.D., described this issue as a "double-edged sword." Physicians who are afraid of being left out of ISNs would be reassured by a requirement that ISNs accept any willing provider. Such a provision would also protect providers from decisions about their inclusion in a network made on the basis of economic factors rather than efficiency and quality of care. On the other hand, an "any willing provider" provision would also apply to all health professionals and would deprive ISNs of their ability to decide the make-up of their provider network. Next session, chiropractors, optometrists, and other allied health professionals are expected to push for legislation requiring that they be used by ISNs. An "any willing provider" provision would strengthen these efforts.

The MMA supports allowing individual ISNs to define their criteria for joining and the requirement that they make the criteria public.

In supporting the MDH criteria provision, the MMA urges that any criteria based upon the efficient use of resources take into account the severity of patient illness and comorbid conditions. Discontinuation of a provider should be based upon valid quality criteria and follow written due process proceedings.

The MMA Board of Trustees approved the MMA position on "any willing provider" as part of the ISN position paper.

Access to Care

The MMA supports the MDH proposal to create geographic ISN service districts as long as the districts are based on existing referral patterns and recognize community health board and regional coordinating board boundaries.

The MMA urges that ISNs be given the flexibility to comply with access standards such as the proposed requirement that primary care be available within 30 minutes travel time or 30 road miles, and be provided within 10 miles of any city with a population greater than 2,500. Efforts to improve geographic access should not prevent ISNs from forming in rural Minnesota.

Standard Benefit Set

The MMA supports the MDH proposal that there be a standardized benefit set for both ISNs and RAPS. The MMA proposes, however, that the benefit set be made explicit rather than merely listing categories of services. The MMA Guaranteed Benefits Task Force is in the final stages of developing a benefit set defining specific medical services. The MMA will forward this benefit set to the MDH and to the Minnesota Health Care Commission and will urge that it be included in legislation.

ISN Solvency

Regarding the proposal that ISNs be allowed a credit of up to 30 percent of their net worth requirements to reflect participation of accredited capitated providers (ACPs), the MMA recommends that the proposal clearly specify that ACPs must be licensed to provide services directly, through contracts, or through an affiliate. The commissioner of health should be allowed to base certification of an ACP upon analyses of providers' audited financial statements. The criteria to establish fi-

Announcements

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Rural ISN Workshops

Rural ISN Technical Assistance Workshops have been scheduled to provide technical assistance in forming integrated service networks in rural Minnesota. Topics include antitrust issues, negotiations with health plans, starting an ISN, purchasing pools, and financing an ISN. The schedule is listed below.

Hadley
Wednesday, January 12
9:00 a.m. - 4:30 p.m.
Community Center
Local sponsor: Southwest Regional Development Commission, 507/836-8547

Mankato
Friday, January 14
9:00 a.m. - 4:30 p.m.
Best Western Garden Inn
Local Sponsor: Region 9 Development Commission, 507/387-5643

To register, contact the local sponsor. A $6 registration fee helps to cover the cost of box lunches for the event. On-site registrations will be accepted only if space is available.

The workshops are sponsored by the Office of Rural Health, the Minnesota Department of Health, the Minnesota Academy of Family Physicians, the Minnesota Medical Group Management Association, and the Minnesota Hospital Association.

Workshops were held in Grand Rapids on January 6 and in Alexandria on January 7.

• • •

Jaspers Will Chair Rural Health Advisory Committee

Anthony Jaspers, M.D., was elected chair of the Minnesota Rural Health Advisory Committee, which advises the Office of Rural Health within the Minnesota Department of Health. Jaspers replaces former chair, Terry Hill.

nancial solvency should be relevant for physicians as well as hospitals. The legislation should also include provisions for the quick liquidation of insolvent ISNs and the redirection of enrollees to other ISNs or the RAPS. If an ISN with which an ACP has contracted becomes insolvent, the enrollees should receive covered services from the ACP for no longer than 90 days.

The MMA supports the state's intent to phase in requirements to allow new entrants into the ISN market and advocates a means test for the ability to phase in. The MMA supports the state's intent to use nationally recognized standards of net worth based on solvency needs in markets with high managed care penetration.

Growth Limits

The MMA notes that the MDH draft provision on growth limits is misleading because it lists the "X" factor, the add-on for medical inflation set by the 1993 statute, as the "projected growth limit" without mentioning that the statute calls for this number to be added to the Consumer Price Index (CPI) in order to set the actual growth limits. For instance, the growth limit for 1994 listed in the MDH draft is 6.5 percent, but this number should be added to the estimated CPI of 2.7 percent for a total estimated growth limit of 9.2 percent for 1994.

Research and Education

Funding for medical research and education is not adequately addressed in the state plan. The MMA supports the use of state and federal general tax revenues to fund medical education and research. In the absence of that funding mechanism, the ISN system and RAPS should share responsibility for funding education and research from patient care revenues. Funds should be allocated equitably to the providers of medical education and research.

Other important issues not adequately addressed in the MDH draft include tort reform, fraud and abuse exemptions, antitrust protection, public health responsibility, grant money for starting up ISNs, and risk adjustment requirements.

Tort Reform

The MMA believes tort reform should be considered an important component of overall health system reform and has listed specific provisions that should be included.

Fraud and Abuse

The MMA supports the MDH draft's statement that ISNs should have the flexibility to decide how they should be structured and supports Minnesota law exempting arrangements between ISNs and their participating entities from state anti-kickback laws. The MMA recommends that the state expand this anti-kickback exemption to include integrated delivery systems within an ISN, such as arrangements among physicians in a clinic without walls. The clinic without walls could be one entity in the ISN. The MMA encourages the MDH and the Minnesota Legislature to support anti-kickback exemptions for integrated delivery systems at the federal as well as state level.

Antitrust Protection

The MMA recommends that current antitrust laws and enforcement policies be changed to allow appropriate collaboration among physicians. While the state's current antitrust exemption process is helpful, it may not provide enough protection for cooperative arrangments. Clarification of federal law is needed. It is not clear how much ongoing "state supervision" of collaborative arrangements is required to provide federal antitrust protection. The state should support federal legislative initiatives that would clarify and strengthen state action exemptions as they apply to physicians and other providers.

Public Health

Responsibility for public health services, such as epidemiological tracking, caring for the uninsured, and personal and custodial services, needs to be clarified. Provisions are needed for people who have special health needs and are not enrolled in an ISN. The MMA will continue to work with the MDH, the Minnesota Health Care Commission, and legislators to improve the implementation plan for ISNs. • • • • •

The National SAFE KIDS Campaign

Do you know a child who was saved from injury or more serious injury because of the use of a safety product such as a bike helmet, child safety seat, safety belt, or smoke detector?

If so, you may be able to help the MMA select a nominee to participate in the SAFE KIDS Summit in Washington, D.C., in May 1994. Two children from each state will be chosen to receive a free trip to the SAFE KIDS Summit, where they will talk to local and national media about safety.

As a member of the Minnesota SAFE KIDS campaign, the MMA is helping to identify children between the ages of 10 and 14, who have had a first-hand experience with a childhood injury. The children may have been saved from injury by use of a safety product, injured because they were not using a safety device and are now safety advocates, helped prevent injury to another child, or lost a sibling because of a preventable injury and are now safety advocates.

Children must be able to travel to Washington, D.C., for the SAFE KIDS Summit May 9-11. All travel expenses will be paid. Children must also be willing to sign a release allowing the National SAFE KIDS Campaign to use their name, photo, and story for promotional and educational activities. The national SAFE KIDS media team will help prepare the children.

If you would like to nominate a child, call Mark Vukelich at the MMA for a nomination form, 612/378-1875 or 800/999-1875. Completed nomination forms are due in the MMA office by February 1, 1994. • • • • •

The Monitor
JANUARY 1994
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Physicians Responsible for Prescribing DMEPOS

Early last year, the Health Care Financing Administration (HCFA) entered into contracts with four carriers to consolidate processing of claims for durable medical equipment, prosthetics and orthotics, and medical supplies (DMEPOS). AIC-AdminaStar in Indianapolis is the Durable Medical Equipment Regional Carrier (DMERC)for Region B, which includes Minnesota as well as Michigan, Wisconsin, Ohio, Illinois, Indiana, Maryland, the District of Columbia, Virginia, and West Virginia.

In Minnesota, the transfer occurred on December 1, 1993, when Minnesota suppliers, including physicians who are also suppliers, began to submit DMEPOS claims to the DMERCs based upon where the beneficiaries live.

AdminaStar Federal Inc. reminds physicians that regulations specify that durable medical equipment (DME) must serve a medically therapeutic benefit in order to be reimbursed under the program. The physician's prescription is the primary source of this information. The physician is responsible for completing the medical documentation supporting the claim for DME and may not charge suppliers or beneficiaries for completing DME certification and recertification forms. • • • • •

AMA *continued from page 37*

Waiver of Co-Payments and Deductibles Under Medicare Part B for Indigent Patients," was adopted following an appeal by A. Stuart Hanson, M.D., on the floor of the AMA House of Delegates. This resolution asks the AMA to seek promulgation of a safe harbor provision by the Office of Inspector General, U.S. Department of Health and Human Services, for the non-routine waiver of Medicare Part-B copayments and deductibles for indigent patients.

Reference Committee B had recommended that the AMA operate under existing policy rather than taking new action to seek a specific safe harbor for waiver situations. In lieu of the Minnesota resolution, the reference committee recommended a substitute resolution reaffirming AMA policy opposing prosecution of physicians who waive Medicare patients' deductibles and coinsurance payments in the interests of their needy patients.

Arguing in favor of the original resolution, Hanson told the House of Delegates, "This is not just a Minnesota issue. Many states face the same problem. We need the AMA's help to get the safe harbors necessary to provide health care for low-income seniors." The House then adopted Minnesota's original resolution.

Regulation of Fee Review Companies

Resolution 208, "Regulation of Fee Review Companies," was referred to the AMA Board. This resolution asks the AMA to develop and support legislation that would authorize the appropriate regulatory agency to review the financial arrangements between for-profit fee review companies and insurance or managed care companies to ensure that these arrangements do not inappropriately induce fee review companies to jeopardize the quality of care or to decrease reimbursement to physicians and other health care providers. • • • • •

MEYER

(continued from page 7)

us from tackling issues with sides that may challenge MMA views. We can find ways of presenting balanced information without taking a point of view. Clearly, we'll have to be a conduit for changes taking place in our state."

Information Exchange

In addition to journals, physicians can use new and established technology, such as on-line computer networks, problem-solving artificial intelligence, PCs, and fax machines, to talk to one another and improve medicine, says Meyer. The capability to transmit patient records almost instantly, share patient databanks with hospitals and pharmacies, and check on a lab report with a push of a button is already here. The ability to employ artificial intelligence to diagnose and suggest treatment options will soon arrive.

Despite these exciting developments, physicians don't typically use computers in their day-to-day practice, says Meyer. "In that way, we're in the Dark Ages." To find information, physicians tend to go to a medical staff librarian, who then uses an on-line computer network service or a CD-ROM reference to answer the doctor's question. Physicians are not likely to know how to access information on their own.

"*Index Medicus* is about 20 volumes of medical knowledge that the computer operator can phone up and access," says Meyer. "You can even access it from home, off your personal computer with a modem."

But many physicians don't utilize these high-tech services. Computer terminals frighten many physicians, particularly those with no keyboard skills. Programs take time to learn, and physicians don't have much time. In order to get physicians to use technology, it has to be more convenient or more powerful than opening a book, says Meyer.

"Right now—today—a physician can leave a patient in an exam room, go to a terminal and punch in a subject, and see options for diagnosis and care right on the screen. This technology is here to use," says Meyer. In the future, artificial intelligence will allow physicians to input symptoms and let the computer help find what might be wrong. "Then we'll have something," he says.

Meyer had his own resistance to computers, initially. "I decided about a year ago that I would only use a computer if I had it right where I worked. If I had to work to get to it, I wouldn't use the thing." Set on a shelf directly in a traffic-filled clinic hallway, the computer and fax are used heavily by staff and by Meyer, who can often be found standing in front of the terminal, typing away on templates he's created to save time.

"The ideal world," says Meyer, "will be when I can put in my patient records and pull them up right there on my screen, get my lab reports and pharmacy refills up on the screen, and collect my messages from the front desk right there, too." MM

Pamela Hill Nettleton is a contributing editor to Minnesota Monthly *and a Twin Cities free-lance writer.*

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People and Places Making Medical News

People

North Central Medical Conference President

The North Central Medical Conference has elected **Richard B. Tompkins, M.D.**, president-elect and chair of the Candidate Selection and Policy Committee. Tompkins is a former president of the Minnesota Medical Association and an internal medicine specialist at the Mayo Clinic.

HealthEast Chief of Staff

Robert V. Drehmel, M.D., has been elected chief of staff at HealthEast Divine Redeemer Hospital in South St. Paul. Drehmel specializes in family practice and is associated with Woodlane Family Practice in Woodbury. He is a diplomat of the American Academy of Family Practice.

Other newly elected officers of the hospital medical staff are **Glenn Burleson, M.D.**, chief of staff-elect; **Kristofer Lund, M.D.**, chair, family practice; **Timothy Potter, M.D.**, chair, department of medicine; **John Lamey Jr., M.D.**, chair, obstetrics and gynecology department; and **Peter Kelly, M.D.**, chair, department of surgery.

Caplan Leaving Center for Biomedical Ethics

Arthur Caplan, Ph.D., director of the University of Minnesota's Center for Biomedical Ethics, is leaving the university next June to establish a similar bioethics program at the University of Pennsylvania in Philadelphia. Caplan, who established the University of Minnesota's ethics center seven years ago, said the University of Pennsylvania is giving him an endowed chair, which means his position is guaranteed and he won't have to seek research grants.

Caplan is the first of the university's nationally renowned professors to depart amid controversies that have shaken the medical school, although Caplan said he is not leaving because of the controversies.

"[The University of Pennsylvania] is an Ivy League school with top 10 law, business, nursing, and medical schools," said Caplan in the Minneapolis-based *Star Tribune*. "And they are about doubling my salary" (from $90,000 a year here). Caplan said he is reluctant to go, but University of Minnesota officials were unable to match Pennsylvania's offer. In addition to money, prestige, and challenge, he said the Pennsylvania position is attractive because his wife is from Philadelphia.

CEO for Children's Hospitals

The boards of Minneapolis Child-Care, Inc., and Children's Health of St. Paul, the respective parent companies of Minneapolis Children's Medical Center and Children's Hospital of St. Paul, announced in mid-November that **Brock Nelson**, current president of Children's Hospital of St. Paul, will be named chief executive officer of the proposed merged organization for an interim period. He will be responsible for ongoing merger planning beginning immediately, but his appointment as CEO will be effective after the merger agreement has been finalized, approved by the respective boards, and filed with the Minnesota secretary of state. The hospitals hope to complete a merger agreement by mid-January to mid-February. The interim appointment will last for approximately 18 months to two years.

Larry Whalen, current CEO of Minneapolis Children's Medical Center, will assume a senior executive role in the merged organization.

Fairview Public Policy Director

Mary Edwards, previously Sen. Dave Durenberger's senior legislative assistant for health, has been appointed director of public policy for Fairview Hospital and Health Care Services in Minneapolis. In the newly created position, she will monitor how state and national policy affects Fairview.

PreferredOne Vice President

Phil Griffin has been named vice president of government affairs for PreferredOne Management Company. In this role, he will lead Minnesota's largest preferred provider organization in its efforts to develop strategies responding to state and national health reform legislation. Prior to joining PreferredOne Management Company, Griffin was director of Legislative and Regulatory Affairs for Medica and assistant director of political affairs at the Minnesota Medical Association.

Minnesota Specialty Physicians CEO

Minnesota Specialty Physicians, Inc., an organization of local physician specialists formed in March 1993, recently appointed **Timothy F. Signorelli**, chief executive officer of the 150-member physician organization. Signorelli, president of Digestive Healthcare, P.A., since 1989, was instrumental in the development of Minnesota Specialty Physicians.

Signorelli is a member of the Minnesota Department of Health's ISN advisory committee and is chair of the health care advisory committee to Rep. James Ramstad, R-Minnesota.

Places

NWNL and Criterion Announce Affiliation

Northwestern National Life Health Management Corp. (NHMC) will provide comprehensive administrative services for Criterion Health-Care Network, a clinics without walls established by Twin Cities physicians. The final agreement was expected to be completed by year end.

NHMC will provide claims administration and a broad range of other services for Criterion's network, which will consist of more than 400 physicians. Criterion will independently contract with employers, managed care plans, insurance companies, and other health plans. It will also participate in NWNL's health maintenance organization, NWNL Health Network.

Hospital, Medical Society Collect Supplies for Homeless

HealthEast St. Joseph's Hospital of St. Paul and Ramsey County Medical Society recently led an effort to collect nearly $7,500 worth of donated medical supplies to help homeless people of St. Paul through neighborhood clinics. The supplies include over-the-counter medicine, hygienic items, and infant care products. The contributions were made by the hospital, east metro physicians, and other health professionals. The supplies will be distributed to the homeless through the Health Care for the Homeless Project, a unit of Catholic Charities.

Minnesota Centers Participating in Cancer Study

The University of Minnesota School of Public Health and the Virginia Piper Cancer Institute at Abbott Northwestern Hospital are among 10 centers from around the nation chosen by the National Cancer Institute to participate in a 16-year, $87.8 million study to determine whether screening tests for prostate, lung, colorectal, and ovarian cancer actually save lives.

The tests to be studied are digital rectal exams and prostate-specific antigen blood tests for prostate cancer, chest x-rays for lung cancer, flexible sigmoidoscopy for colorectal cancer, and transvaginal ultrasound, pelvic exams, and a blood test for ovarian cancer.

"Some of these tests are being widely promoted, but we don't know if they are effective," said epidemiologist Jack Mandel, Ph.D., a professor in the university's School of Public Health and principal investigator for the university.

The 10 sites will recruit 148,000 men and women aged 60 to 74 for the study. The two Minnesota centers hope to enroll more than 20,000 Minnesotans. Half will undergo comprehensive screening and half will be told to continue with their normal care. The number of people who die of cancer from each group will be compared.

State Awards AIDS/HIV Case Management Grants

Seven Minnesota community organizations have been chosen to receive approximately $1.1 million in state and federal grant money to provide case management and other services for people with HIV. The money will fund programs designed to help people with HIV find appropriate health and social services and to help coordinate delivery of those services. The grants will also fund efforts to help people with HIV make changes in their behavior so they can prevent further spread of the virus.

Approximately 620 Minnesotans with HIV made use of case management services during the past year, according to Minnesota Commissioner of Health Mary Jo O'Brien. Up to 30 more people, newly diagnosed with HIV, may require case management services every month.

The grants awarded include $45,000 for the Minnesota American Indian AIDS Task Force; $47,000 for Turning Point, Inc.; $45,000 for Chicanos Latinos Unidos En Servicio; $45,000 for the University of Minnesota Youth and AIDS Program; $90,000 for Ramsey Foundation; $190,000 for the Minneapolis Medical Research Foundation; and $490,000 for the Minnesota AIDS Project.

The Minnesota AIDS Project will receive an additional $95,000 to develop a new program called the Centralized Assistance Project, which will provide a range of services for people who don't want or don't qualify for case management services.

MTC Bans Tobacco and Alcohol Advertising

The Metropolitan Transit Commission voted unanimously to ban all tobacco and alcohol advertising on its buses. Implementation will occur throughout the year. Bus shelters in Minneapolis and St. Paul are owned by another company and may still carry tobacco and alcohol advertising.

Socioeconomics

Medica and HealthSpan Merging

Two of Minnesota's largest health care organizations, Medica and HealthSpan, have agreed to merge, forming a new firm called Allina. If state and federal regulatory agencies approve the merger, Allina will include Medica's health plans with their 550,000 enrollees and 5,000 physicians, and HealthSpan's 17 hospitals and long-term care facilities and its 45 clinics.

Officials at Medica and HealthSpan say health plan enrollees' benefits won't change, nor will the hospitals' relationships with doctors and health plans. The merger is in response to health

system reform and provides the basis for an ISN.

HealthSpan itself is the product of a merger between LifeSpan and Health One Hospital Systems, and Medica was formed by merging Physicians Health Plan and Share health maintenance organization.

HealthPartners, Ramsey Complete Agreement

HealthPartners and Ramsey HealthCare Inc. completed in December their agreement to merge. The agreement finalizes the deal first announced in September, which includes St. Paul-Ramsey Medical Center, Ramsey Clinic, and Ramsey Foundation.

The merger must be approved by the state Legislature, since St. Paul-Ramsey Medical Center was created by statute. Officials at HealthPartners say they don't expect this to be a problem. In the meantime, HealthPartners will operate the hospital, clinic, and foundation under a management contract. Robert Garland will continue to serve as president and chief executive of Ramsey HealthCare and will become a senior vice president of HealthPartners.

Meanwhile, St. Paul-Ramsey Medical Center is implementing three large building projects. The first, an $11 million outpatient and 24-hour urgent-care center, was inspired by HealthPartners, which Garland says is "in tune with what patients and clients want." Ramsey is also starting a $6 million emergency room expansion this spring, and a $6.2 million burn center is now under construction.

HealthPartners health plans will phase in admission of patients to the medical center over the next year. Some patients will continue to be admitted to St. John's Hospital in Maplewood and St. Joseph's in St. Paul. The merger will not affect HealthPartners patients in the west metro area, who are referred primarily to Fairview hospitals; however, officials said HealthPartners is discussing alignments with providers on the west side.

Minnesota Specialty Physicians and Medica Collaborating

Minnesota Specialty Physicians, Inc., and Medica have agreed to collaborate on the delivery of specialty care to Medica members. Together, the organizations will apply practice guidelines to specialty care delivery, share data, and make changes to reduce administrative costs. Additionally, Minnesota Specialty Physicians will work to make specialty care more available in Greater Minnesota.

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Minnesota Specialty Physicians is a 157-member physician organization that provides a variety of specialty services to the Twin Cities, including Medica members.

Primary Physicians Form Coalition

Nine physician group practices that include more than 200 primary care physicians at 32 medical clinics have formed Physicians Service Network (PSN), a new coalition that will offer managed care services in the seven-county metro area. Health care buyers can now contract with PSN as a whole, rather than with each practice group independently.

Although some hospitals and specialty physicians have joined to market their services, PSN is the first metro-wide, physician initiated, primary care coalition in Minnesota. The founding practices are Bloomington Lake Clinic, Camden Physicians, Columbia Park Medical Group, Family Physicians, Lakeview Clinic, Metro Family Physicians, Multicare Associates, North Clinic, and Northwest Family Physicians.

Gary A. Van House, chief executive officer of PSN and chief executive director of Columbia Park Medical Group, said the clinics are free to contract with health care buyers independently as well as through the network.

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MMA's
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Information Available:

- House File 1178 MinnesotaCare Legislation
- MMA's Campaign Against Family Violence Materials
- Information on Services Available through Minnesota Medical Business Resources

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HealthEast Acquires Two Clinics

In an effort to line up partners for an integrated service network, HealthEast has acquired two St. Paul physician clinics. The two groups are Highland Family Physicians at Randolph and Snelling avenues in St. Paul and Metro Family Physicians, which includes Payne Avenue Medical Associates, Vadnais Heights Family Physicians, and the Rice Street Clinic.

Group Health Premium Increase Angers Seniors

Group Health announced in late November that it plans to increase premiums for its Seniors Plus plan by 29 percent, in addition to a new $10 copayment for most doctor visits and a $30 payment for using an emergency room. After receiving notices of the premium increase, hundreds of angry seniors called the Minnesota Senior Federation to complain. Premiums for the plan, which is a federal demonstration project that offers social services, increased about 20 percent last year. Group Health is increasing premiums for its more conventional Medicare HMO plan, Group Health Seniors, by nearly 24 percent.

The news was better for seniors enrolled in Medica. Those enrolled in SeniorCare Basic and SeniorCare Plus will see no premium increase if they live in Hennepin and Ramsey counties. For those who live outside those two counties, and for those whose premiums cover prescription drugs, premiums will increase 10 percent to 17 percent. Premiums for Medica's PHP+Medicare plan will not increase in the metropolitan area, but non-metro members will see increases of 1.2 percent to 13.9 percent.

Both Group Health's and Medica's rate increases must clear the Minnesota Department of Health's HMO unit. Patsy Riley, Medica's Medicare director, and George Halvorson, president and chief executive officer of HealthPartners, parent company of Group Health, blamed the increases on low Medicare reimbursement rates.

Law & Policy

Suits Against AIDS-infected Doctor Reinstated

The Minnesota Court of Appeals has reinstated claims filed by former patients of the late Philip Benson, M.D., who continued to treat patients after he was diagnosed with AIDS. The suits are against Benson's estate and the Palen Clinic, where he worked.

Hennepin County District Judge Ann Alton previously threw out the patients' claims, ruling that they had to prove they had direct contact with Benson's blood or bodily fluids before they could seek damages. The Court of Appeals said "actual exposure" is not necessary. "Plaintiffs here need show only that they were in the zone of danger of contracting HIV, that they reasonably feared for their safety, and consequently suffered emotional distress." The court said patients who were given evasive answers when they asked Benson or clinic personnel about his open sores and weight loss can also seek damages for battery. In addition, patients on whom Benson performed "invasive" procedures without telling them about his AIDS can pursue claims for negligent nondisclosure.

Rates, Trends, Data

Minneapolis Shows High Rates of STDs for White Women

Thirty-nine percent of sexually active young white women surveyed in Minneapolis in 1989 said they have had a sexually transmitted disease, according to a report in the November-December issue of *Public Health Reports*, the journal of the U.S. Public Health Service.

"That is higher than the rates we found among white women in Chicago [25 percent], Birmingham [17 percent], and Oakland [33 percent]," said Sandra Melnick, a former University of Minnesota researcher who left 15 months ago to join the National Institutes of Health's AIDS project. She said the STD rates for white men, black men, and black women surveyed in Minneapolis were very close to those in other cities. The higher rates for white women in Minneapolis could be attributed to a better public health system in Minnesota. "It is possible that Minnesota has just done a better job of getting these diseases diagnosed," she said.

The questionnaires were sent to more than 2,700 men and women whose average age was 30. The respondents were asked whether they had ever been diagnosed with chlamydia, syphilis, genital warts, genital herpes, or gonorrhea. In Minneapolis, 21 percent of 199 white men had been diagnosed with at least one sexually transmitted infection, as well as 39 percent of 276 white women, 42 percent of 74 black men, and 44 percent of 117 black women. Overall, the numbers were 21 percent of white men, 33 percent of white women, 37 percent of black men, and 43 percent of black women.

Few Students Who Abuse Drugs Receive Treatment

Ramsey and Hennepin county officials are concerned that too few student drug abusers are being identified and treated. According to a 1992 survey by the Minnesota Department of Human Services, 996 students from Ramsey County and 2,231 from Hennepin County in grades six, nine, and 12 were abusing drugs. However, just 276 Hennepin students and 94 Ramsey students received treatment.

School and county personnel say getting students into treatment is difficult for many reasons. Some students lie about chemical abuse, many parents don't know or won't admit their children have a problem, and insurance companies don't always cover chemical treatment.

Don Mockenhaupt, director of Mental Health and Chemical Dependency Services in Ramsey County, wants to concentrate his efforts on Central and Highland Park high schools next year by hiring a chemical health specialist to study the magnitude of drug use at the schools and increase the number of students referred to treatment. Hennepin County already collaborates with the city of Minneapolis, United Way, and the school district to identify students with problems at earlier stages. Hennepin is using chronic truancy as an indicator that students could be using drugs or alcohol.

Hantavirus Identified in Minnesota

Minnesota is the 13th state to confirm cases of hantavirus, the deadly disease that struck the southwestern United States this past spring and summer. State epidemiologist Michael Osterholm, Ph.D., said that officials at the Centers for Disease Control and Prevention in Atlanta confirmed that the virus nearly killed a middle-aged man from Norman County in northwestern Minnesota. The man was in intensive care for 36 days in the spring of 1992 but has since recovered.

Osterholm said health department staff are investigating the possibility that other Minnesotans may have been infected with the virus. He also expects to see new cases.

The disease symptoms are similar to influenza, but some victims vomit, as well. The victims develop acute respiratory distress syndrome and breathing becomes labored as fluid accumulates in the lungs. "This is a serious condition," said Osterholm. "Immediate hospitalization is mandatory."

Physicians who suspect one of their patients may have the ailment are urged to contact the state health department immediately for details on the antiviral drug ribaviron, which is being tested as a possible cure for the disease. Because the illness is carried by small rodents such as field mice, it normally occurs in rural areas, but Osterholm said the Twin Cities area also is home to a large number of field mice. MM

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A Calendar of Continuing Medical Education Courses

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JANUARY 1994

Jan. 10-14 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.

Jan. 12-16 **Bone and Soft Tissue Tumors** Mayo Foundation; Mauni Lani Bay Hotel, Kohala Coast, HI. CONTACT: Rita Kunz or Jan Fleck, Section of CME, Siebens 5, Mayo Foundation, 200 First Street SW, Rochester, MN 55905; 507/284-2509 or 800/323-2688.

Jan. 31-Feb. 4 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.

FEBRUARY 1994

Feb. 4 **Duluth Clinic Family Practice Conference** Duluth Clinic; Fitger's Theatre of the North, Duluth, MN. CONTACT: Rockie Odberg, 400 East Third Street, Duluth, MN 55809; 218/725-3838.

Feb. 5-9 **Selected Topics in Internal Medicine** Mayo Foundation; Silverado Resort, Napa, CA. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME, Siebens 5, 200 First Street SW, Rochester, MN 55905; 507/284-2509 or 800/323-2688.

Feb. 10-14 **Mayo Clinic State-of-the-Art Symposium: Arrhythmia Management** Mayo Foundation; Napa Valley, CA. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME, Siebens 5, 200 First Street SW, Rochester, MN 55905; 507/284-2509 or 800/323-2688.

Feb. 18 **Infectious Disease in Immunocompromised Patients** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Feb. 18-24 **A Winter Olympics Study Trip: Advances in Diagnostic Radiology** University of Minnesota, Department of Radiology; Oppdal, Norway. CONTACT: Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Feb. 21-22 **Advanced Trauma Life Support (ATLS)** HealthSpan; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7910.

Feb. 21-25 **Neurology in Clinical Practice** Mayo Foundation; Keystone Resort, Keystone, CO. CONTACT: Rita Kunz or Jan Fleck, Section of CME, Siebens 5, Mayo Foundation, 200 First Street SW, Rochester, MN 55905; 507/284-2509 or 800/323-2688.

Feb. 23-24 **Geriatric Drug Therapy Symposium** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Feb. 24-25 **Advanced Pediatric Life Support** Hennepin County Medical Center; Hennepin County Medical Center, Minneapolis, MN. CONTACT: Rachel Knudson, R.N., EMS Training, Hennepin County Medical Center, 701 Park Avenue South, Minneapolis, MN 55415; 612/347-3638.

Feb. 24-26 **Epilepsy Update—Basic Mechanisms of Anticonvulsant Treatment** Minnesota Epilepsy Group/Barrow Neurological Institute; Buttes Conference Resort, Tempe, AZ. CONTACT: Annette Carlson, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7910.

Feb. 25 **Annual Burn Care Today Conference** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Feb. 25 **Prevention and Management of Atherosclerotic Diseases** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

MARCH 1994

Mar. 3-4 **Gentle Journey: Annual Conference on Palliative Care** HealthEast Hospice and Carondelet HealthCare Foundation; St. Paul Radisson, St. Paul, MN. CONTACT: HealthEast Hospice, 69 West Exchange Street, St. Paul, MN 55102; 612/232-3051.

Mar. 3-4 **Medical Update 1994** University of Minnesota Department of Surgery, Continuing Medical Education, Medical School, Continuing Education and Extension; Fort Lauderdale, FL. CONTACT: Medical Update 1994, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Mar. 5 **The Cure of Breast Cancer** HealthSpan Health Systems Corp, Hotel Sofitel; Bloomington, MN. CON-

TACT: Don Young, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

Mar. 5 **Schizophrenia Update** Behavioral Health Services of Abbott Northwestern Hospital; Minneapolis Hilton & Towers, Minneapolis, MN. CONTACT: Don Young, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

Mar. 7-11 **Medical Update 1994** University of Minnesota Department of Surgery, Continuing Medical Education, Medical School, Continuing Education and Extension; Fort Lauderdale, FL. CONTACT: Medical Update 1994, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Mar. 10 **Medica Foundation/University of Minnesota Lecture Series on "The Task of Medicine: A Rich Past and an Open Future." Beethoven and Medical Practice in 19th Century Vienna** University of Minnesota Program in Human Rights and Medicine and Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Mary Krumholz, 1121 Marion Street, St. Paul, MN 55117; 612/487-9715.

Mar. 10-11 **Annual Family Medicine Today Conference** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Mar. 11-12 **Advanced Life Support in Obstetrics (ALSO)** HealthSpan; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7910.

Mar. 17-18 **Allergy and Clinical Immunology** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Mar. 17-18 **Critical Care: A Focus on Practical Management** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Mar. 19-25 **Radiology: Brain to Pelvis 1994** University of Minnesota; Pines Lodge, Beaver Creek, CO. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Mar. 24 **Medica Foundation/University of Minnesota Lecture Series on "The Task of Medicine: A Rich Past and an Open Future." Ethical Aspects of the Human Genome Project and Genetic Science** University of Minnesota Program in Human Rights and Medicine and Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Mary Krumholz, 1121 Marion Street, St. Paul, MN 55117; 612/487-9715.

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1994 Winter-Spring Conference Schedule

February 25	Burn Care Today, St. Paul
March 10-11	Family Medicine Today, St. Paul
March 17-18	Critical Care 1994: Practical Approaches & Case Discussions, St. Paul
March 25	15th Annual Occupational Medicine Update, Mpls
April 7-8	Annual Ob/Gyn Update, St. Paul
April 8	ENT Update, St. Paul
April 15	Multidisciplinary Approaches to Common Primary Care Problems, St. Paul

Information and registration:
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NO PHONE CALLS PLEASE.

Mar. 25 **Fifteenth Annual Occupational Medicine Update** St. Paul-Ramsey Medical Center; Minneapolis Metrodome Hilton, Minneapolis, MN. CONTACT: Bonnie Young, Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Mar. 25-26 **Eating Disorders** University of Minnesota; Sheraton Inn Midway, St. Paul, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Mar. 25-27 **Third Annual Conference on Advances in Clinical Anesthesiology** Mayo Foundation; Amelia Island Plantation, Amelia, FL. CONTACT: Rita Kunz, Mayo Foundation, Section of CME, Siebens 5, 200 First Street SW, Rochester, MN 55905; 507/284-2509 or 800/323-2688.

Mar. 31 **Progress in Health Care Reform: Minnesota and the Nation** University of Minnesota; Sheraton Inn Midway, St. Paul, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

APRIL 1994

Apr. 7-8 **Annual Ob/Gyn Update** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 7-9 **Nineteenth Annual Spring Continuing Education Seminar** Minnesota Academy of Physician Assistants; Holiday Inn-Airport, Bloomington, MN. CONTACT: Sonja L. Gedko, PA-C, 8575 Magnolia Trail, 203, Eden Prairie, MN 55344; 612/944-9388.

Apr. 8 **ENT Update** St. Paul-Ramsey Medical Center; St. Joseph's Hospital, St. Paul, MN. CONTACT: Bonnie Young, Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 14-16 **Trauma of Upper Extremity Fractures and Dislocations of Wrist, Elbow, and Shoulder** Mayo Foundation; Scottsdale, AZ. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME, Siebens 5, 200 First Street SW, Rochester, MN 55905; 507/284-2509 or 800/323-2688.

Apr. 15 **The 10th Annual Duluth Heart Conference** Duluth Clinic; Duluth Entertainment & Convention Center, Duluth, MN. CONTACT: Rockie Odberg, 400 East Third Street, Duluth, MN 55805; 218/725-3838.

Apr. 16 **The Treatment of Prostate Cancer** Minnesota Urological Society; Minneapolis Hilton and Towers, Minneapolis, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875.

Apr. 21 **Medica Foundation/University of Minnesota Lecture Series on "The Task of Medicine: A Rich Past and an Open Future"** Program in Human Rights and Medicine, University of Minnesota, Continuing Medical Education; Grand Ballroom, Radisson Hotel Metrodome, Minneapolis, MN. CONO

TACT: Mary Krumholz, 1121 Marion Street, St. Paul, MN 55117; 612/487-9715.

Apr. 22-23 **Minnesota Orthopaedic Society 10th Annual Meeting** Minnesota Orthopaedic Society; Phillips Hall, Siebens Education Building, Rochester, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875.

Apr. 29 **Agricultural Health & Safety** St. Paul-Ramsey Medical Center; Location to be announed. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

MAY 1994

May 12 **Central Minnesota Medical Conference** St. Cloud Clinic of Internal Medicine, Ltd.; St. Cloud Holiday Inn, St. Cloud, MN. CONTACT: Kellee Zwilling, 1200 Sixth Avenue North, St. Cloud, MN 56303; 612/240-2155.

May 12-13 **Primary Biliary Cirrhosis: A Look to the Future** Mayo Foundation; Kahler Plaza Hotel, Rochester, MN. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME, Siebens 5, 200 First Street SW, Rochester, MN 55905; 507/284-2509 or 800/323-2688.

May 19-21 **Disability Evaluation & Management** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

May 20 **1994 Emergency Medicine Conference** Duluth Clinic; Duluth Entertainment & Convention Center, Duluth, MN. CONTACT: Rockie Odberg, 400 East Third Street, Duluth, MN 55805; 218/725-3838.

JULY 1994

July 14-15 **Advanced Pediatric Life Support** Hennepin County Medical Center; Hennepin County Medical Center, Minneapolis, MN. CONTACT: Rachel Knudson, R.N., EMS Training, Hennepin County Medical Center, 701 Park Avenue South, Minneapolis, MN 55415; 612/347-3638.

AUGUST 1994

Aug. 22-Sept. 2 **Twelfth Annual Occupational Health and Safety Institute** St. Paul-Ramsey Medical Center; University of Minnesota, Mayo Building, Minneapolis, MN. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

SEPTEMBER 1994

Sept. 22-23 **Domestic Violence** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

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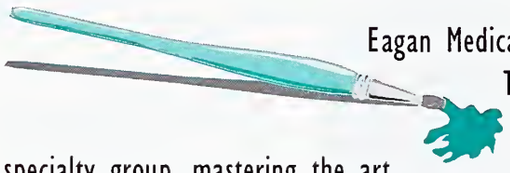

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MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

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Wisconsin: 120-physician multispecialty clinic in the Fox River Valley of northeastern Wisconsin desires two BC/BE pediatricians to join department of 15 BC/BE pediatricians. Excellent compensation and benefits package, leading to shareholder status after two years. The community offers a superb recreational, cultural, and family environment in which to practice. For information please call or write Howard Kidd, M.D., La Salle Clinic, 411 Lincoln Street, Neenah, WI 54956; 414/727-4276. (3/91-R)

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Internal Medicine, Pediatrics, and Dermatology practice opportunities available at the Faribault Clinic. The Faribault Clinic is a multispecialty group practice of 19 physicians. Faribault is located 50 miles south of Minneapolis on I-35. For more information contact Ray W. Wood, M.D., or Ken Smith, Administrator, 924 NE First Street, Faribault, MN 55021; 507/334-3921. (4/90-R)

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Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

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Wisconsin—Internist Wanted: Group Health Cooperative, a progressive, growing, primary-care group practice in a city of 60,000—90 miles from Minneapolis/St. Paul—is currently recruiting a third BC/BE internist. Very competitive salary with excellent fringe benefits. Practice high-quality internal medicine in a most desirable location. Please contact James A. Volk, M.D., Medical Director, Group Health Cooperative, PO Box 3217, Eau Claire, WI 54702-3217; 715/836-8552. *3-3/94

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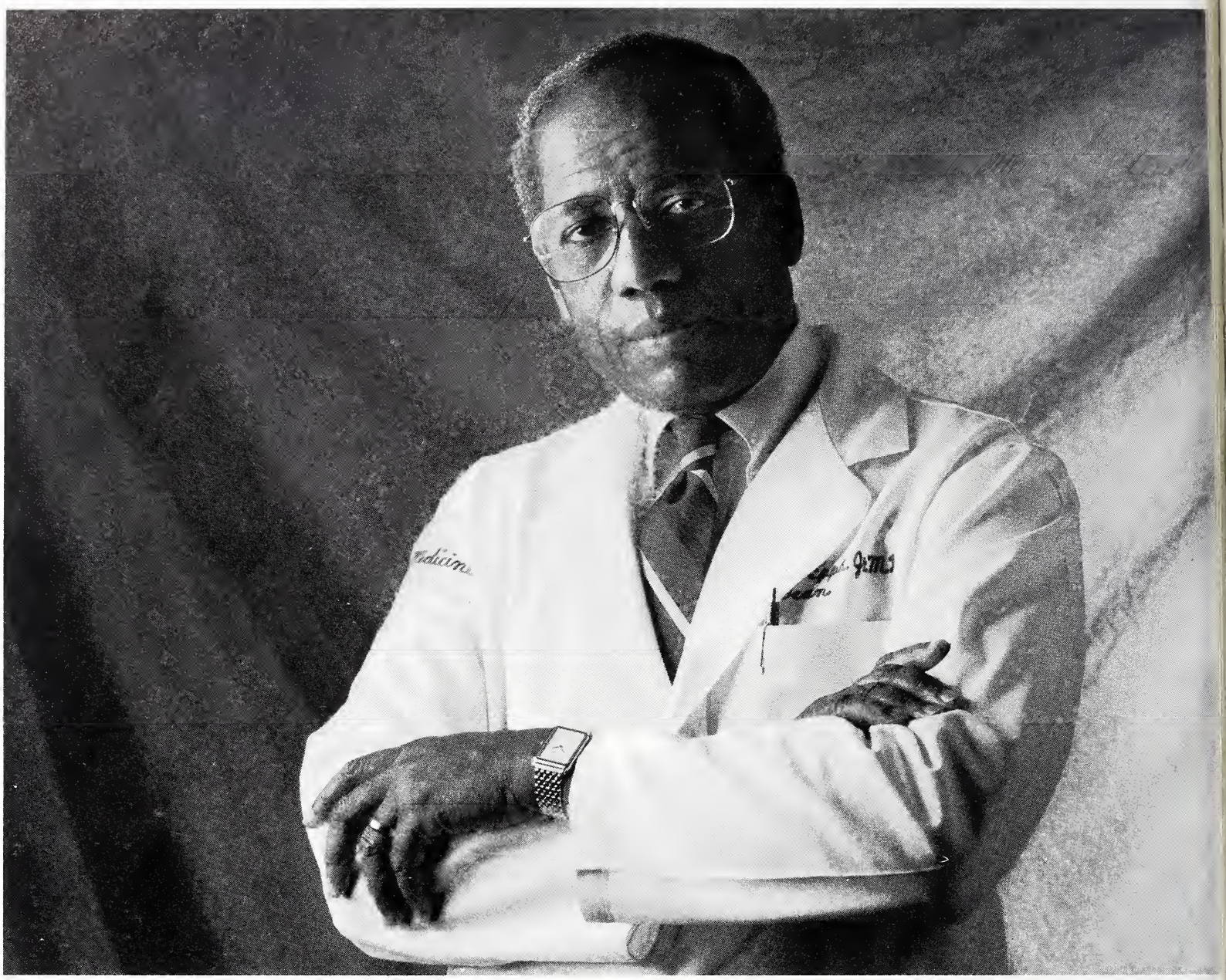

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Call for Papers

1994 International Conference on Physician Health
September 16-20, 1994. Ottawa, Ontario, Canada

"Stress: The Profession, the Family and You"

The 1994 International Conference on Physician Health, co-sponsored by the American Medical Association, the Federation of State Medical Boards, the Canadian Medical Association, and the Federation of Medical Licensing Authorities of Canada is scheduled for September 16-20, 1994, at the Ottawa Westin Hotel.

Ottawa is Canada's capital and offers many national museums, over 60 miles of bicycle paths, hiking in Gateneau park, squash courts and swimming at the hotel and golf nearby.

The conference will provide a forum for practitioners and researchers to present recent findings and innovative treatment and education programs in physician health. This conference will address a range of issues, such as AIDS, HIV, problems related to aging, mental illness, substance abuse and physical disabilities and limitations, including those caused by general medical conditions. Possible topics for presentation include: presentation and treatment of health problems among physicians, the impact of disorders on physicians' families and practices, medical-legal issues facing hospital administrations and licensing boards, and material on health promotion and disease prevention. *Abstracts which address issues related to these topics (i.e., prevention, diagnosis, treatment, rehabilitation), but not dealing specifically with physicians are also welcome.*

Three types of presentations regarding these physician health issues are invited:

- **Poster Presentations**
  Written presentations of data-based research, epidemiological research, or program descriptions.

- **Paper Sessions**
  Oral presentation of scientific, data-based findings relative to the topic of physician health.

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- **Workshops**
  Training or instructional presentations, designed to improve specific skills of persons who work in the area of physician health.

  Abstracts for workshops should contain information on the program's intended audience, goals, teaching strategies, and materials. Evaluation data should be summarized

Abstracts may not exceed 200 words. Any abstracts exceeding that length will be rejected. Abstracts should be typed, double spaced, and mailed (not faxed). Four copies of the abstract should be sent, along with one self-addressed, stamped envelope. All submissions must list the primary and secondary authors and their professional affiliations. Telephone number and address of primary author must also be included.

Submissions *must* be received by February 1, 1994.

Abstracts will be submitted for blind review. Abstracts will be judged on their applicability to the conference topic area and their scientific merit. The decisions of the blind reviewers will be communicated to the abstract's primary author by April 1, 1994.

All presenters are expected to register for the conference at the AMA member rate. We are unable to provide any financial support for presenters. Presenters will also be responsible for their own transportation and hotel expenses, as well as making all reservations for same.

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Are We Getting the Message?

Charles R. Meyer, M.D.

I firmly believe that if the whole materia medica could be sunk to the bottom of the sea, it would be all the better for mankind, and all the worse for the fishes.

–Oliver Wendell Holmes

Skepticism about conventional medical practice is not new. Critics from alternative care philosophies have long viewed established scientific medicine as, at best, a closed, provincial fraternity and, at worst, a dangerous pack of inhumane technicians. Peering across the fence from the other side, mainstream medicine sees snake-oil charlatans preying on the ignorant sick. Few words have passed between the two camps, yet both have flourished in their own way. Why have they both survived? And is there really so little in common between the two philosophies? Two articles in this issue shed light on these questions.

Our cover story, by Douglas Clement (page 10), describes the rise of such alternative healing practices as acupuncture, herbal medicine, and holistic medicine locally and nationally. The article relates the creeping acceptance of acupuncture and Chinese-based medicine in a citadel of academic medicine, Hennepin County Medical Center.

Paul Brown provides a more detailed depiction of one form of alternative health care, chiropractic, from an M.D.'s perspective. He analyzes the history, training, philosophy, and practice of chiropractic and challenges the validity of many of its beliefs (page 21).

A few generalizations are clear from these articles:

1. Alternative health care is popular and growing. In addition to the facts presented by Clement, witness the recent three-part series in the unlikely "journal" *Consumer Reports* (January through March 1994).

"Alternative health care speaks loudly of the power of the healer to heal with low-tech touch and talk."

2. Established medicine is taking alternative health care seriously. Despite its relatively meager $2 million budget, the Office of Alternative Medicine (OAM) has received 452 proposals for 30 pilot grants. The OAM has established rigorous methodologies to evaluate these proposals and judge alternative therapies by scientific standards.

3. Regardless of future scientific proof or refutation, alternative health care will likely provoke continued loyalty from certain patients and hostility from physicians. It is unlikely that medicine will soon meet the patient needs satisfied by alternative health care. It is unlikely that chiropractors and orthopedists will soon agree on the significance of subluxation or that most medical clinics will welcome holistic healers.

What should scientific medicine learn from alternative health care? Chiropractors, acupuncturists, and naturopaths succeed because of conventional medicine's perceived failings. The medical problems for which patients most frequently seek unconventional treatment—back problems, anxiety, fatigue, headache, insomnia—are infrequently cured and inadequately comforted by conventional medicine. The promises of technology seem hollow for these sufferers. Many alternative therapies involve a close bonding between treater and treated with frequent visits, laying on of hands, and attention to the patient's psyche. Even before the advent of psychoimmunology or the popularity of holistic medicine, any practicing clinician should have discovered the physical power of psychological health. Patients need to feel our attention and our concern. Regardless of its scientific footings, alternative health care speaks loudly of the power of the healer to heal with low-tech touch and talk.

So medicine should stare across the fence at unconventional care's message with curiosity, not hostility. The message is that we do not know all there is to know about the body and pain and suffering and that our first duty to those who suffer is to care and comfort even if we cannot cure.

Also in this Issue

Like a struggling swimmer, tort reform keeps bobbing up. We never know whether it will emerge healthy and refreshed or whether it will be drowned by political wranglings. Three articles in this issue address different facets of the medical liability problem (pages 8, 26, and 31).

Perhaps with the aid of state and national health reform initiatives our swimmer will survive. MM

George Halvorson Talks Reform

HealthPartners' president and CEO has his own prescription for health care reform—the right incentives.

BY JOSEPH MORIARITY

With words like uncertainty, turbulence, and chaos descriptive of today's health care system, few people would consider this an ideal time to be CEO of a large health care organization. George C. Halvorson is one who does.

"With the industry in transition, I have an incredible opportunity to influence reform, to implement new incentives that will reward quality and efficiency. I love my job and consider myself very lucky to be here," says Halvorson, president and chief executive officer of HealthPartners, the parent company of Group Health and MedCenters Health Plan.

When Halvorson joined Group Health, Inc., from Blue Cross-Blue Shield in 1986, health care reform was still in its gestation period. "There was some talk in the industry about insurance changes, but nothing about restructuring delivery systems or financing arrangements," says Halvorson. "Managed care was considered an 'alternative' delivery system." That "alternative" now accounts for 80 percent of the Twin Cities health care market, and it is the cornerstone of President Clinton's national reform proposal.

Although Halvorson welcomes health system reform, frustration with the way it is playing out prompted him to write his recently published book, "Strong Medicine" (Random House, 1993), a frank discussion about why our health care system isn't giving America what it wants, needs, or could be getting—and what can be done to make it better. (See page 43 for a review of the book.) Halvorson's 25 years in health care make him well-suited to write about reform. Besides heading HealthPartners, he is chair-elect of the Group Health Association of America and is on the Minnesota Health Care Commission. Before the merger that formed HealthPartners, he was president and CEO of Group Health, and previously he held executive positions at Blue Cross. During his career, he has developed two HMOs, Senior Health Plan and HMO Minnesota.

The Right Incentives

"While everyone agrees on the need to reform the current system, few people truly understand how it works or what incentives drive it," says Halvorson. "Consequently, too many influential people are focused on fixing only part of the problem. How often do you hear, for example, that major malpractice reform would really help the system? Yet the cost of malpractice insurance is less than 1 percent of our health care costs. Cutting those premiums in half would mean only a *one-time* savings of 0.5 percent of our health care costs. Since defensive medicine is often lucrative, costs related to this practice aren't likely to shrink much either. We can't solve our health care problem with malpractice reform alone."

Furthermore, Halvorson argues, if we want to change the system, we don't need more government regulation, greater expenditures, or health care rationing. "Instead, we need the right incentives. If we reward quality and efficiency, the health care system in this country will turn itself around to provide them."

Increasingly, that's what consumers are demanding. Particularly in the Twin Cities, patients and buyers of health care are creating large purchasing groups, and providers are competing over prices and services. It is precisely such market competition that Halvorson firmly believes is needed to drive reform. "It will be the primary means to control costs, improve quality, enhance consumer choice, and generally increase the value of our health care dollars," he says. "We will rely on private health plans to assume cost risks and deliver care, and on the state to establish authorities to structure competition."

PHOTOGRAPH BY BRUCE BAIRD

"If we reward quality and efficiency, the health care system in this country will turn itself around to provide them."

–GEORGE HALVORSON

Competition and Better Care

Provider competition for customers is essential to controlling costs and improving quality. But two recent mergers in the Twin Cities—the HealthSpan-Medica agreement to form the 570,000-member Allina, and the merger of HealthPartners (580,000 members) and Ramsey HealthCare—have prompted managed care supporters as well as critics to question whether reforms will be overwhelmed by the major players. Some analysts predict that health care in the metro area will be provided by three to five systems within a year. How this will affect pricing and competition is unclear.

Halvorson, who describes HealthPartners' merger with Ramsey HealthCare as "another major step in our ongoing effort to create a fully integrated system," says such concerns are unwarranted because they are based on obsolete assumptions. "The marketplace's traditional measure for competition has been reduction in unit price costs, but we are no longer competing on this basis. Thus, the price of individual procedures matters very little. What matters instead is the health of the member population and the annual costs for their care," he explains. "We've never had competition between health systems based on a population's health after being cared for by one system versus another. Not only will we still have competition regardless of the number or size of the systems, but at last it will be focused on the right goal. Buyers of heath care want to know which system is fostering the healthiest population at the lowest total cost per year."

Capitated Care

Though the norm in Minnesota, managed care is hardly without its critics, and Halvorson himself readily admits that capitated care, per se, is not a panacea for the health care system's problems. "I learned by experience in the early years of HMO capitation that it's possible to badly design *any* reimbursement program and create perverse incentives," says Halvorson. "Capitation won't necessarily align everyone's incentives in a way that controls costs and produces quality."

To prevent under-delivery of care—a major worry of managed care critics—reporting on outcomes and

HALVORSON continued on page 42

When the Game Is What Counts

After observing a medical malpractice trial, a physician finds he cannot reconcile his world with that of the plaintiff's attorney, a onetime friend.

Dear Ben:

You and I had been friends for years. Although you are an attorney and I a physician, our relationship had been personal, not professional. I was interested, therefore, when an opportunity arose to watch you work. More than one year ago, you were one of a team of lawyers representing the plaintiff in a medical malpractice lawsuit. The plaintiff was a man whose wife died within hours of being admitted to the hospital. He alleged that care by the admitting physician had been negligent.

I decided to watch the trial for all of its 40 hours. I felt the pain of the treating physicians as they testified. I heard the jury announce its verdict in favor of the plaintiff. The experience confirmed for me that although you and I live in the same city, we live in different worlds.

Let's go back. You know well the facts of the case. The defendant was one of several physicians caring for the patient. The other defendants had settled before trial for large amounts. The remaining defendant and her insurance company chose to defend the case because they were convinced she acted appropriately. After watching the trial, I believe they were right. She provided good care. However, a jury trial is a difficult place to explain the subtleties of diagnosis and roles of different medical providers. It is also a terrible place to be the last defendant when others have already settled, whether or not you did anything wrong.

BRUNO PACIULLI

I learned a great deal during the trial. I learned about the cold calculation of an attorney assessing the "jury appeal" of a case. I learned how you and your colleagues communicate on several levels at once, signaling contempt by body language and tone of voice. These never appear in the transcript of a trial, but seem at least as influential to the outcome as the words that do.

I learned how fascinating your world can be, Ben. I found myself plotting strategy to attack from strength and to defend weaknesses. I enjoyed the challenge to use language precisely, to present logic clearly. I felt the exhilaration of the fight. However, having visited the world in which you work, I am repelled by it.

As a physician, I hold at least three values that are different from yours. First, I believe in science as an approach to truth. Although we may not always be able to label a patient's problem accurately or

measure it precisely, physicians believe there is, nonetheless, a physical truth about illness. For example, we believe that some people develop appendicitis. Even if we called it a headache or conversion symptom, the physical reality of the inflamed appendix would remain. Physicians seek to discover scientific truth and act on it to the benefit of patients.

As advocates, attorneys do not seek objective truth. Rather, you deal in persuasion, in applying meaning to ambiguous data. The goal of litigation is to dispose of disputes, not find truth in the scientific sense. Truth is what the jury says it is. You win if you persuade jurors of your version. The trial demonstrated clearly that jurors do not understand concepts that professionals take years to learn. Defendants in medical malpractice cases are not tried before a jury of their peers. You profit from this.

The second difference concerns pain. Medical ethics dating back to at least Hippocratic teaching emphasizes that the physician's role is to help, not hurt, our patients. Despite this, physicians sometimes deliberately hurt people. We perform painful tests and procedures. We prescribe distressing medications. We sometimes hurt people unintentionally, out of misdiagnosis, improper therapy, or complications of appropriate treatment. This is inevitable in medicine. It is rarely true malpractice, and our objective should always be to do more good than harm.

As a plaintiff's attorney, you seek to "even the score." For your client to win, the other side must lose. Thus, you make a living off creating winners and losers. You, by definition, must hurt someone to serve your client and feed your family.

The third difference is that when I go home from work, I do not deliberately act in a way contrary to my role as a physician. To nurture your family, care for your neighbor, or be a friend, you must act contrary to your role in the courtroom. Physicians are repeatedly amazed at how lawyers fight viciously in front of the jury and later join in camaraderie and fellowship. The game is what counts, the test of intellect, of wills. You have been taught not to take it personally. To an observer, plaintiffs and defendants appear as incidental props on the field where you and the opposing attorney share your fun.

I learned some things about myself, too, Ben. I learned that I have limits to my ability to understand, accept, and forgive. My revulsion about what happened is as intense today as it was one year ago. I confess my failure to reconcile my world with yours. I have not overcome my emotional response with reason.

However, I also learned what I cherish. I value personal caring, the scientific approach to finding truth, and the use of knowledge and power to enhance life. Despite the risk, I choose to remain vulnerable, to stay personally invested in my patients. I must do so to provide the best care of which I am capable.

Ironically, even telling you these things represents risk. Having watched the process, I assume you will use my thoughts and feelings to refine your attack on my colleagues or me in the future. I am already aware of your many well-rehearsed rebuttals to my points. A common impulse physicians experience in response to the threat you represent is to withdraw, practice rigidly defensive medicine, change specialties, or leave medicine entirely. I reject these, because to give in to fear would be to give up being the kind of person and physician I want to be.

Ben, you and I have known each other for years. I had come to like, trust, and respect you. It is, therefore, with an extra measure of sadness that I acknowledge I cannot overcome the barrier your career has placed between us. I cannot recover the trust in you I once had.

Your work helps push our medical professional liability system out of control. This destroys the basic relationship essential to good health care. Physicians and patients need a delicate, mutual confidence not easily restored once it is damaged by suspicion or open attack. So do friends.

So, unlike you and your colleagues, I do indeed take it personally. We cannot go back to the friendship you and I once had, and for that I grieve.

Sincerely,

George

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Considering the Alternatives

Considering the Alternatives

Considering the Alternatives

ILLUSTRATION BY ELIZABETH LADA

Considering the Alternatives

Unconventional therapies are gaining popularity and making inroads into mainstream medicine.

It is a waiting room like any other: A fish tank gurgles in the corner. A receptionist handles calls. Patients thumb through *Family Circle*. But behind the doors of this particular clinic lies a world of exotic herbs, meridians, Chi, and the fragile balance of Yin and Yang.

By Douglas Clement

"There's a difference between being skeptical with an open mind, and being skeptical and hostile with a closed mind."

–*Milton Bullock, M.D.*

This is the Acupuncture and Alternative Medicine Clinic, and though its name and healing modalities would seem to place it on the outer fringes of American medical practice, its staff and operations sit squarely under the direction of Hennepin County Medical Center's Department of Medicine.

In Minnesota—indeed, in the entire country—there is perhaps no single clinic that better illustrates the slow but certain integration of alternative healing modalities into established health care institutions.

"I can't think of another place in the United States that has, within the department of medicine, a full-range traditional Chinese medicine clinic," says Patricia Culliton, M.A., Dipl.Ac. (diplomat of acupuncture) and director of the clinic, which is part of Hennepin Faculty Associates. Culliton oversees a clinic staff of three certified acupuncturists, who treat illnesses that vary from urinary frequency and hot flashes to strokes and chronic pain. Another 12 acupuncturists work in the clinic's off-site programs for addictions and mental illnesses.

Culliton herself is trained in acupuncture and herbal medicine, so well-trained, in fact, that in 1988, she was named Acupuncturist of the Year by the American Association of Acupuncture. And this past November, Culliton was the only American asked to speak at the 2,800-person World Acupuncture Congress held in Kyoto, Japan. "In all honesty, I think that we're actually behind a lot of other countries," admits Culliton. Fewer than 1 percent of Americans have used acupuncture, whereas many European countries and most Asian nations have far higher acceptance and use rates.

But this is likely to change, primarily because consumers are demanding it. "I think that all of the interest is consumer-driven," says Culliton. "Many people are experiencing syndromes [for which] they aren't getting a lot of relief from traditional Western medicine and so they're looking for alternative health care. It's growing exponentially."

The clinic's medical director, Milton Bullock, M.D., of HCMC, appreciates conventional medicine's powers to heal but also acknowledges its failures. "I have a great love for the Western system of medicine ... but like an increasing number of physicians, I also realize that with many types of chronic debilitating conditions that I've tried to treat with medications and so forth, I simply have not been overly successful."

The HFA clinic is an outgrowth of 10 years of research by Culliton, Bullock, and others on using acupuncture to control recidivism among alcoholics. In a placebo-controlled study published in *The Lancet*, they reported "significant treatment effects [which] persisted at the end of the six-month follow-up." Compared with patients treated with acupuncture, the control patients had more than twice the number of drinking episodes and admissions to detox.[1]

"Frankly, I was somewhat pessimistic at first," recalls HFA President Fred Shapiro, M.D., a nephrologist with extensive background in clinical research. "But in reviewing the pilot study I felt there was something there. When we had the same sort of results the second time around ... it made no sense not to apply it."

A dozen years ago—after a bout of pneumonia put her in the hospital—Helen Stenzer decided to quit smoking. "A nurse told me about acupuncture," says Stenzer, recalling her hospital stay. "And she said, 'Whatever you do, don't tell anyone around here that I told you,' because it was contrary to Western medicine."

So without telling her doctor, Stenzer visited a small office on Lake Street in Minneapolis. An acupuncturist took her pulse, looked at her tongue, and then inserted three stainless steel needles into each ear, two into each wrist, and four into her chest. After two more visits, Stenzer quit the pack-a-day smoking habit she'd had for 30 years.

Unfortunately, after four years of abstinence, she

began smoking again. But in December 1993, Stenzer decided anew that it was time to quit. She returned to her acupuncturist. By this time, however, Pat Culliton had moved from Lake Street to HCMC and was too busy to treat Stenzer directly. Wei Liu, Culliton's colleague at HFA and a doctor of Oriental medicine, performed a treatment very similar to Stenzer's 1981 acupuncture and had equally successful results. "It really is a miracle," says Stenzer. "It seems I feel the effects almost immediately."

Stenzer is one of 500 patients that the HFA clinic sees each month, up from 100 a month when it opened in January 1993. Clients pay about $40 for a consultation and treatment, except during the drop-in clinic held three times a week, when patients pay about $10 per visit.

There are five individual treatment rooms at HFA, each with posters illustrating more than 300 acupuncture points on the human body and corresponding points on the ear. In the rooms, patients lying on high padded tables are covered with blankets, lights are turned down, and soft music is played to help patients relax during treatment. "We use pre-sterilized disposable needles and throw them all away after use," emphasizes Culliton. Small electrical devices with alligator clips can be attached to the needles to provide subcutaneous electrical stimulation.

Treatment may include herbal remedies, an integral part of Chinese medicine that is still viewed suspiciously by Western medicine, even though, as Culliton points out, "some people say that 60 percent of American pharmaceuticals are based in herbal products." Still, the clinic has a "pharmacy" with five shelves filled with Chinese herbs, most of which are American-produced and approved by the FDA as food supplements. Each small jar gives the Latin name and in small letters underneath, the Chinese classical formula.

"Rehmannia 16 is a Latin name for a Chinese herb," explains Culliton, holding a bottle of herbs. "Underneath it says 'Bu Yin Pian: Strengthen, cool-nurturing pill,' so these pills strengthen your Yin or cool you off. These pills might be appropriate for people with hot flashes or just kind of feeling hot, not being able to sleep at night because they're too anxious."

If this sounds strange, no one is more aware of it than Culliton's colleagues at Hennepin Faculty Associates. A year ago they were resistant to sponsoring the acupuncture clinic, but now, according to HFA's Shapiro, they're referring patients. "They can't deny it when somebody comes in with severe edema and [Culliton] gives them a treatment and they have a massive diuresis. You can't argue with the results," says Shapiro. "I see some day that this will be spreading all over the country."

The Prevalence of Alternative Therapies

Alternative therapies—ranging from the respectable (acupuncture, meditation) to the ridiculous (crystal-healing, iridology)—are already more popular than medical scientists might like to believe. According to a widely quoted survey in the *New England Journal of Medicine*, 34 percent of Americans surveyed in 1990 reported using at least one "unconventional" therapy in the past year.[2] In fact, far more visits were made to unconventional therapists than to primary care medical doctors (general and family practitioners, pediatricians, and specialists in internal medicine). Extrapolating to the entire U.S. population, the study estimates 425 million patient visits to unconventional therapists versus 388 million to medical doctors.

Almost 90 percent of those who saw an unconventional therapist did so without an M.D.'s recommendation, and 72 percent of all unconventional therapy users did not inform their medical doctors that they were using an alternative, perhaps because they were embarrassed, or maybe because no one asked.

Annual expenditures in the United States for unconventional therapies were estimated by the study at $13.7 billion, $10.3 billion of which came out-of-pocket, compared with $12.8 billion spent out-of-pocket for hospital care and $23.5 billion out-of-pocket for physicians' services.

No comparable survey has been done in Minnesota, specifically, but indications are that alternative therapies are at least as popular here as elsewhere in the country, and that growth over the past decade has been dramatic.

When it opened in 1978, Turtle Island Health Center in St. Paul was the only integrated holistic health center in the Twin Cities. Now there are a half dozen similar clinics. Turtle Island itself has grown significantly. "I went from shared office space with one receptionist to a staff of 10 to 12 people at this point," says Russell DesMarais, D.C., Turtle Island's founder and director. "And we serve between 40 and 60 patients a day."

Edith Davis, president of the Minnesota School of Acupuncture & Herbal Studies, recalls that when she began her acupuncture practice in Minneapolis 15 years ago, there were three acupuncturists in the state and "maybe a handful of M.D.s who were very, very quietly placing some needles in people." Now there are about 50 nationally certified acupuncturists practicing here, along with another 500 to 600 chiropractors who use acupuncture as an ancillary procedure and an uncounted number of Asian practitioners with non-institutional training. The number of physicians practicing acupuncture in the state is growing, but the exact number is unknown, since many physicians attend short courses but do not seek certification.

In that same period, the number of licensed chiropractors has nearly doubled to 1,500 statewide, reports Scott Mayer, director of the Minnesota Chiropractic Association. And according to a 1987 MCA survey, says Mayer, "Sixty percent of Minnesotans had been to a doctor of chiropractic for health care."

Add to that the burgeoning number of massage therapists, homeopaths, naturopaths, and other practitioners of what many prefer to call "complementary" therapies, and it's clear that when Minnesotans feel bad, they're as likely to go to a non-medical healer as to an M.D.

If the image still isn't crystalline, visit Present Moment bookstore in Minneapolis: Three large rooms filled wall-to-wall, floor-to-ceiling with books, herbs, homeopathic remedies and other alternative health products, and a line of customers 15-deep waiting to step up to the cash register. "Our store has come quite a ways," says Bob Gallagher, an herbalist who started Present Moment in 1980 "with the idea of providing an alternative to drug medicine." He's reluctant to give out exact sales figures, but he claims that "according to our suppliers, we're the largest in the country in retail in homeopathic medicine. Every year it keeps on going up. We've never leveled off."

Present Moment accountant Kathleen Anderson says part of the reason may be that patients are frustrated with traditional medicine's tendency to treat symptoms, not the patient. "People really want to be healed, and a lot of them want to be more in charge."

Shifting Paradigms in Health Care

The American public's love-hate relationship with the medical profession is not news. Medicine is worshipped for its ability to cure the most acute, life-threatening illnesses, but many patients are dissatisfied with its inability to provide answers for such problems as chronic pain and chronic fatigue, and with the impersonality of a health care system that often treats patients like widgets to be poked, thumped, injected, billed, and discharged.

"The average person is wanting and demanding what they need, and what they need is somebody who can address their care from a more individual and holistic perspective rather than tossing them around the system," says Howard Bell, who holds a master of divinity, was coordinator of hospice care for Abbott Northwestern Hospital from 1979 to 1987, and currently is the director of Pathways, a health crisis resource center in Minneapolis.

"We need our well-trained, high-tech physicians, by all means," adds Bell, "but we also need them to respect that their technology doesn't always apply, and that sometimes a complementary therapy will work better."

Bitter medicine. Are physicians taking it?

Traditionally, of course, the stance of modern medicine has been to view most non-medical therapies with skepticism, if not scorn. Faith healers and shamans were viewed as quacks and charlatans. Herbal remedies were considered folk myths.

"We reject all knowledge which is merely probable and judge that only those things should be believed which are perfectly known and about which there can be no doubts," said Descartes, whose philosophy led to

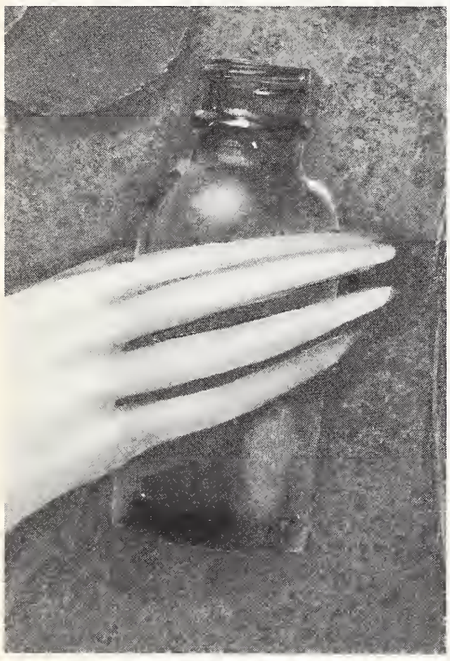
> We need our well-trained, high-tech physicians, by all means, but we also need them to respect that their technology doesn't always apply."
>
> –*Howard Bell, M.Div.*

the scientific method, and whose mind-body dualism underpins Western medical practice.[3]

But this distinguished tradition is slowly giving way, for reasons scientific, political, and economic.

The New Science

The American medical community's misgivings about alternatives began to erode in the early 1970s, after *New York Times* columnist James Reston wrote about acupuncture treatments he received in China. A decade later, Robert Ader, professor of psychosocial medicine at the University of Rochester, published "Psychoneuroimmunology," in which he explored the peptide-mediated dialogue between nervous, immune, and endocrine systems.[4] Psychoneuroimmunology argues that emotional and mental states strongly influence physical states, hinting at healing techniques that biomedicine never dreamed of. Several groundbreaking studies gave deeper and deeper credence to the theory.



In 1989, David Spiegel, M.D., a psychiatrist at Stanford University, reported in *The Lancet* that women with metastatic breast cancer who get "psychosocial treatment," including support group meetings and self-hypnosis, along with medical care live twice as long as patients who receive only medical care.[5]

A year later, in another *Lancet* article, Dean Ornish, M.D., of the Preventive Medicine Research Institute in Sausalito, California, demonstrated that techniques like yoga and meditation, combined with a low-fat diet, can help reverse coronary heart disease by reducing the amount of plaque in the arteries.[6,7]

Other careful studies have found recently that Chinese herbs are effective in the treatment of eczema and that psychological stress increases susceptibility to the common cold and other respiratory viruses.[8,9] Even homeopathy, a theory that makes no sense to the Western biomedical mind, has actually found guarded support in conventional medical journals.[10]

And over the past 10 years, Western scientists have shown to their partial satisfaction that acupuncture needles do provide an analgesic action, presumably through the release of endogenous opioid peptides. Others have reported that acupuncture stimulation actually increases some aspects of immune function (increased beta-endorphin in peripheral blood mononuclear cells and increased T-lymphocyte proliferation).[11]

Many of these therapies contradict the strict Cartesian dichotomy of mind and body. Others contradict reality altogether. Distinguishing between the two won't be easy, and only recently have scientists turned to the task.

Politics and Prices

In 1992, at the behest of Congress, the National Institutes of Health established an Office of Alternative Medicine (OAM) to foster research into unconventional therapies. The OAM has an annual budget of $2 million, a piddling sum compared with NIH's $10 billion budget, but a boon nonetheless to a field that has never had official federal backing. Using this small sum, the OAM has begun to provide seed grants for alternative medicine research programs.

Critics complain that the benefits of any such research "are unlikely to outweigh the publicity bonanza given to quack methods."[12] Supporters, on the other hand, bemoan the small budget. "I don't think that it's a very high priority for NIH," admits Pat Culliton, who was involved in OAM's establishment. "But you know the old Chinese saying: 'The journey of a thousand miles begins with the first step,' and this is the first step."

Further steps will depend on higher economics. Some early efforts to provide holistic health care in Minnesota faltered because insurance companies were unwilling to cover costs. The Wellness Center in Mankato began to provide time-intensive holistic health care to patients 10 years ago. Treatment included acupuncture, homeopathy, herbal medicine, nutrition counseling, and biofeedback.

But the center had so much trouble with insurance payments that it had to scale back in 1988, says founder Bill Manahan, M.D. "Insurance companies would pay for a 15-minute history and $1,000 worth of lab tests," he says. "But they wouldn't pay for a thorough hour and a half history with very little lab work. It was discourag-

ing, but, hopefully, times will change."

Perhaps they have already. Under MinnesotaCare, integrated service networks will soon predominate Minnesota health care, and some in the field believe ISNs will be more receptive to alternative therapies. "People are clearly willing to pay out-of-pocket for non-traditional complementary care," says Noel Baker of the Lamat Corp., a Minneapolis health care consulting firm. "There's a lot of incentive there for a hospital to say: 'That's a market.' What we're suggesting is that one of the more attractive provider groups to be considered in the next decade will be complementary care providers."

> "People are clearly willing to pay out-of-pocket for non-traditional complementary care."
>
> –Noel Baker

Culliton notes that Blue Cross and Blue Shield has just started to cover patients at her clinic "on a case-by-case basis." Nationwide, other insurance companies are slowly accepting the trend. California's American Western Life Insurance Co. began this year to offer coverage for a network of 300 providers of acupuncture, aroma therapy, biofeedback, chiropractic, herbal medicine, massage, naturopathy, reflexology, and yoga. And Mutual of Omaha announced in July that it would reimburse the costs of Dean Ornish's non-surgical therapy for heart disease.

Never the Twain Shall Meet?

Although they remain exceptions to the rule, some medical doctors and alternative therapists are beginning to work together.

Each Monday afternoon, orthopedic surgeon David Naden, M.D., drives from Riverview Medical Center in St. Croix Falls to Forest Lake, where he consults with Richard Ottomeyer, D.C, at the Kari and Ottomeyer chiropractic clinic. "They're going to run across some cases they can't take care of," says Naden, "and obviously we can't take care of everything either." So Naden and Ottomeyer consult with and refer to one another.

According to the Minnesota Chiropractic Association, two Minnesota hospitals—in Moose Lake and Grand Marais—have given chiropractors privileges to see and treat patients on site, and many more allow chiropractors laboratory privileges. Various HMOs also provide chiropractic services, usually under an M.D.'s supervision.

Some HMOs are exploring other nontraditional therapies as well. "We're not just looking at the traditional pharmacological approaches," says psychologist David Alter, Ph.D., clinical site director for HealthPartners' mental health services. "We sometimes use the word 'biopsychosocial' to describe treatment that eliminates a mind-body split in the way we deal with our patients. Biofeedback, relaxation training, meditation, yoga, talk therapy, those are all different approaches we use."

In hospitals, pain management programs are usually the areas most receptive to unorthodox therapies, if only because conventional measures have failed or are contraindicated. The HCMC Pain Clinic and Abbott Northwestern's Sister Kenny Pain Management Program, for example, use biofeedback and acupuncture, among many other techniques.[13]

Which Ones Work?

Eyebrows were raised recently at Park Nicollet Medical Center when Dale Anderson, M.D., circulated a memo to 600 fellow physicians announcing PNMC Board of Directors support for the development of an "Office of Adjunctive Medicine" and asking doctors to join seven study clubs to "identify non-conventional treatments that help patients feel better, that do no harm, and that REDUCE costs."

PNMC administration has since clarified that the center has no immediate plans to establish such an office, but that it has given Anderson support to go ahead with the study groups. "Good old conservative Park Nicollet, we're going to do acupuncture? No, not true at all," says Park Nicollet spokesperson Amy Pak.

But Anderson is encouraged by the response to his proposal for study groups. "About 40 replies in the first week," he says. A general surgeon currently practicing biomechanical medicine in Park Nicollet's orthopedics department, Anderson is a walking advertisement for biopsychosocial medicine. He advocates humor as medicine and argues that placebo effects should be explored and exploited, not dismissed.

"I'm 60 years old, and much of the time it was my understanding, and my education, that if I kept people healthy, then happiness would be the result," says Anderson. "But now we're finding out that laughter can create happiness, and that there's a profoundly important reversal of the equation, with happiness creating health."

The rules of medicine are being rewritten. Paradigms

"If when you look at something you look with the purpose of discrediting it, then you'll never find the truth."

–*Dale Anderson, M.D.*

are shifting. Medical doctors are being asked by both patients and colleagues to re-examine much of what they've learned. And skepticism toward the unorthodox is both justifiable and counterproductive.

"I think the people who say that it's total quackery sometimes are not willing to even look at it or study it," says Anderson. "And if you don't look at it with an open mind, if when you look at something you look with the purpose of discrediting it, then you'll never find the truth."

Which is not to say that some therapies and their proponents don't deserve discredit. Bloodletting was once a conventional medical technique. Iridology has not found scientific validation.[14,15] And some ostensibly benign alternative treatments have, in fact, produced a lower quality of life, according to patients themselves.[16]

Any therapeutic technique—be it entrenched or eccentric—deserves unprejudiced inquiry, not uncritical embrace. And the question remains: Which alternative modalities work?

"There's a difference between being skeptical with an open mind, and being skeptical and hostile with a closed mind," says HCMC's Milton Bullock. "Many of my colleagues are skeptical but open-minded, willing to look at data, willing to look at results. That's all we ask." MM

Douglas Clement is a Minneapolis-based free-lance writer.

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Immunization Initiatives

National and local programs have cut costs and increased access, placing immunizations at the leading edge of health system reform.

James E. Levin, M.D., Ph.D., and G. Scott Giebink, M.D.

"We're from the federal government, and we're here to help." While many Minnesota physicians shudder at the very prospect of more government involvement in their practices, new laws and programs have already affected those who provide childhood immunizations. The debate surrounding immunization initiatives provides opportunities to explore a number of larger health system reform issues, including cost containment, access to care, quality and outcome measures, local variations of national policy, and patient confidentiality. This article examines the success of certain immunization initiatives, largely the result of partnerships between physicians and policymakers, and considers the lessons these improvements hold for comprehensive health system reform.

Controlling Costs

Cost control is the imperative driving much of health care reform. Two facets of our national immunization program have successfully lowered the cost of vaccine delivery—the National Childhood Vaccine Act of 1986, which established a new means of compensating persons injured as the result of routine vaccination, and the Comprehensive Child Immunization Act of 1993, which brings even greater cost containment. As a result of the compensation program, no physician has been sued for a vaccine-related injury since 1988; new manufacturers are coming into the vaccine market; and the cost of vaccines, which in some years had increased more than 200 percent, has stabilized or decreased, as in the case of DTP.

Perhaps similar medical liability reform could spread savings of this magnitude throughout our health care system. President Clinton's health system reform package would require that all liability claims be submitted through an alternative dispute resolution system established by each health plan. The president's plan would also establish a medical liability pilot program in which a physician who demonstrates compliance with appropriate guidelines would not be liable for medical malpractice. Minnesota's own health system reform legislation, MinnesotaCare, has a similar provision.

The second immunization program, the recently enacted Comprehensive Child Immunization Act of 1993, authorizes the Department of Health and Human Services to negotiate with manufacturers to purchase large quantities of vaccine at dramatically discounted prices. Beginning October 1, 1994, each state will be required to purchase enough vaccine for all children who are Medicaid-eligible, uninsured, Native American, or who receive their shots at public health clinics. States will have the option of purchasing additional vaccines at the same discounted price for children not included in these categories. Vaccines will be distributed free of charge to all public and private health care providers who are willing to participate in the program. Providers may charge a vaccine administration fee established by the secretary of Health and Human Services, but only to parents who can afford it. Potential savings from this program are significant. Last year, the full series of immunizations recommended through 6 years of age cost $96 when purchased in bulk by the federal government, compared with $208 when purchased by private physicians in the retail market.

Providing Universal Benefits

The Minnesota Child Health Insurance Reform Plan of 1988 required that all health insurance sold in Minnesota cover child health supervision services, including routine immunization, without deductibles or copayments. Unfortunately, self-insured companies escape this mandate through a federal ERISA exemption; thus, about 40 percent of insured Minnesota children must pay for routine immunization. Neither MinnesotaCare nor the 1993 Immunization Act fully addresses this inequity. Notably, Clinton's Health Security plan would extend preventive care to Americans of all ages without copayments or deductibles.

Mandating universal vaccine benefits would help ensure that every child has a "medical home." Providing immunizations is the best way to get children into

personal, primary care with a doctor who knows the child well. Primary care is comprehensive and continuous, includes early detection and treatment of illness, guides parents on injury prevention and behavior management, and saves money by reducing unnecessary, often duplicate, testing and treatment.

As MinnesotaCare strives to provide comprehensive health benefits for all children, providers must take seriously their responsibility to increase compliance with preventive services such as immunizations. Even when comprehensive benefits are available, many barriers to access, educational lapses, and missed opportunities contribute to under-immunization.

"Providing immunizations is the best way to get children into personal, primary care with a doctor who knows the child well."

Because up to 85 percent of Minnesota children receive their immunizations in the private sector, the Minnesota Department of Health has invited private practices and managed care plans to demonstrate their willingness to share responsibility for improving state immunization practices. The Minnesota Department of Health's Immunization Practices Task Force, composed of representatives from both public- and private-sector organizations, is charged with assisting the department in developing and maintaining a coordinated public and private vaccine delivery system.

As part of its Minnesota Immunization Action Plan, the Department of Health funded 24 Community Immunization Action Plans with a $900,000 federal grant to enhance immunization practices in the state. While most of the plans use traditional public health interventions, a few also plan for education of private health care providers and collaboration with day-care providers and employers.

The Centers for Disease Control and Prevention, the American Academy of Family Practice, the American Academy of Pediatrics, and other medical and public health organizations recently endorsed a set of 18 national standards for immunization providers. These standards do not distinguish between public and private clinics. All facets of immunization services are covered, including scheduling, tracking, vaccine storage and administration, informed consent, valid contraindications, and family and provider education. Although these standards currently are not requirements, physicians, managed care plans, and public clinic providers who develop policies that effectively address these standards will greatly improve the quality of their patient care.

The Children's Hospital of St. Paul has established formal policies to comply with all 18 standards. These include a commitment never to turn away an under-immunized child because of inability to pay, a plan to develop community outreach and culturally sensitive educational programs, and a plan to use all clinical encounters to screen and, when indicated, immunize children. As part of the hospital's immunization plan, the emergency department will consult patients' primary providers and make immunizations available to all patients who are behind schedule.

Measuring Quality

Quality "report cards" rating the performance of health plans are a centerpiece of Clinton's reform package. It is anticipated that health plans will be evaluated in approximately 50 categories, and these results will be distributed annually so that individuals can make more informed decisions when choosing a plan. Similarly, MinnesotaCare mandated the creation of a Data Institute, which will gather information to compare Minnesota health plans on the basis of selected quality measures. Local managed care plans have provided national leadership in this area.

Immunization practices have attracted the attention of individuals involved in outcomes measurement because they use some of the least complicated, least controversial, and most cost-effective of all practice guidelines. For example, the CDC's Healthy People 2000 immunization goal is 90 percent compliance with the primary series of four DTP, three polio, and one MMR immunization on or before 24 months of age.

Although using one standard measurement by which to compare health plans may seem attractive, Minnesota Department of Health epidemiologists recently called attention to the difficulty of using a single number to reflect immunization performance. In a study of all 69,000 Minnesota children entering kindergarten in 1992, the department measured immunization levels at five different ages during the children's first two years of life. Different problems were detected in communities throughout the state, sometimes even in adjacent postal zip code zones. For example, in some communities, the first set of immunizations was delayed and children stayed behind schedule. In other communities, early immunization levels were high until the 18-month vaccine doses were due.

Moreover, measures developed for retrospective population-based surveys cannot easily be applied prospectively to the members of individual health plans. There is a danger that goals intended as minimal standards will become ceilings and needed childhood immunizations will be delayed until the CDC-recommended 24-month "deadline." Furthermore, retrospective surveys do not work well for under-immunized children who move from one health plan to another. For example, one Minnesota health plan recently advertised that 67 percent of its 2-year-old enrollees were fully immunized in 1991, but the calculation excluded all children not continuously enrolled in the plan. Adopting this method

of measurement might remove an incentive for providers to apply the more complicated catch-up vaccine guidelines to a high-risk population of frequent movers. On the other hand, including these children in the calculations might be seen as unfairly penalizing providers. It would be tragic if conducting outcomes measurement created a disincentive for health plans and providers to enroll or serve those in greatest need.

Missed opportunities to vaccinate under-immunized children and physician misinterpretation of vaccine contraindications are two of the most significant problems in vaccine delivery. For continuous quality improvement efforts to succeed, new yardsticks must be developed for measuring the ability of physicians, health plans, and public clinics to address these common pitfalls. Ideally, these measurements will reflect provider performance but will not be affected by patients who move frequently, by changes in patient demographics or immunization schedules, or variations in families' compliance with scheduled clinic visits. If measurement is to be a means of achieving health system reform, physicians must insist upon appropriate and useful yardsticks.

Finding Local Solutions

Minnesota vaccine providers realize that, for many patients, the existing system is working well. But for those whose needs are not being met, the problems vary. Every group that is under-immunized may be affected by different barriers requiring different interventions. Thus, the Minnesota Immunization Action Plan not only invited private-public collaboration, but recognized that communities need individualized plans. Each of the 24 recently funded community immunization action plans was developed after evaluating detailed local immunization statistics, and each plan targeted barriers and needs specific to its community.

Nationally, the diversity of immunization problems and practice also makes the notion of a global solution impractical or inefficient. One of the formidable challenges of health system reform is to allow each region of this very diverse country to build on its strengths and address its own weaknesses. The diversity of immunization practice requirements is apparent in controversies surrounding recommendations for automated tracking and reminder systems. Federal legislation that would have mandated the creation of computerized state registries and a national tracking system was defeated. A national system would be complex and costly, and its benefits are unproven. A state tracking system may be appropriate where the majority of vaccine is administered in public clinics, but in Minnesota any system must allow for the full participation of private providers. In addition, providers must be able to exchange this information electronically. Ironically, developing private provider-based systems may obviate the need for a comprehensive state or national system.

The Minnesota Department of Health encourages each provider group to take responsibility for tracking and reminding its own patients. By linking provider reports to birth records, the state could ensure that each child is connected with a primary care physician. Such an approach is consistent with the Clinton administration proposal requiring each state to be responsible for ensuring that all eligible individuals enroll in a health care alliance and have access to a health plan that delivers comprehensive benefits.

In the meantime, as we await the advent of automatic electronic tracking and exchange, immunization providers in Minnesota are examining new ways to facilitate communication. These efforts include the Minnesota Gold Card, a wallet-sized immunization record first distributed in 1991, and streamlined inter-clinic communications using fax transmissions and standardized forms. In 1992, Minnesota law was amended to allow providers, schools, and public health agencies to exchange—without the patient's consent—information on the date and type of immunizations administered.

Assessing Confidentiality vs. Efficiency

A recent Institute of Medicine report on the computerized patient record identified immunization records as an example of medical data requiring the lowest level of security and confidentiality protection. However, it may be possible to infer from immunization records that a child or family member has a compromised immune system, such as with HIV infection or cancer chemotherapy, because live virus vaccines are usually contraindicated for these patients. In this light, one wonders whether or not immunization information should be available through a national system to every emergency room and school office. Even releasing the dates and location of vaccine administration could jeopardize the confidentiality and safety of a family that has found a haven from violence, abuse, or discrimination related to an illness.

A system of linked provider-based systems would protect the confidentiality of the medical record by allowing providers familiar with a patient's special needs to control the release of information, as they do today. Physicians need to examine carefully the potential breaches in patient confidentiality that could result from abdicating this control to a national tracking system.

National systems require a national identification number, and most current proposals link immunization records to Social Security numbers. A new national health identification number, similar to that proposed by President Clinton, would have many advantages over the use of Social Security numbers. Without linkage to tax, job, and other financial information, a national health identification number would not create the incentive for fraud inherent in the Social Security number. Additionally, a separate number would facilitate the creation of a longitudinal electronic patient record for tracking treatments and preventive care and for evaluating health plan quality and efficiency.

Similar cost and privacy issues will no doubt surface when data collection initiatives are underway as part of national health system reform.

continued

Conclusion

In many ways, controversies in immunization delivery offer a preview of the debate surrounding comprehensive health care reform. Immunization providers have learned that it is politically difficult, but ultimately necessary, to achieve universal benefits. We have also found that vaccine cost can be controlled, but cost is only one of many barriers. Finally, we've discovered that quality measurement and tracking systems are not just details to be considered later by information technicians; physicians and other health care providers must be actively involved in every step toward health care reform. MM

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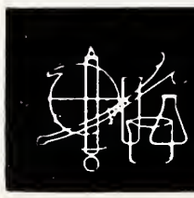

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Chiropractic: A Medical Perspective

Paul Brown, M.D.

ABSTRACT

Chiropractic health care is founded on the premise that many diseases are the result of spinal nerve impingements or interference. These nerve impingements are postulated to be the result of misaligned vertebra or "subluxations." Research indicates that spinal manipulation may be beneficial in low back pain, but the claim that spinal manipulation is of value for optimizing general health and treating non-musculoskeletal conditions is unfounded.

A recent study published in the *New England Journal of Medicine* surveyed use of "unconventional medicine" in the United States and found that 7% of the general population had seen a chiropractor in the preceding 12 months.[1] Since a small but significant segment of the population has used chiropractic, physicians need a basic understanding for advising patients.

History

Although bonesetters of various types have been present for centuries, chiropractic (meaning "hand practice") traces its origins to Daniel David Palmer, an Iowa grocer and "magnetic healer," who in 1895 claimed to have cured a janitor of deafness by adjusting a bump on his spine. Despite the obvious anatomic oversight, Palmer went on to postulate that most disease is the result of nerve interference caused by misaligned vertebra he referred to as "subluxations."[2,3] Palmer further theorized that the body's "Innate Intelligence" could restore health if these subluxations were corrected by manipulation, and he claimed that the germ theory, medication, surgery, and medical diagnosis were irrelevant.[3] ("Innate Intelligence" is a metaphysical term coined by Palmer implying the concept of vitalism.) Palmer, and more importantly, his son, B. J. Palmer, went on to establish a school of chiropractic and to teach their philosophy of health care.[2,4]

Education, Theory, and Practice

The original Palmer school had a curriculum lasting less than nine months, and a correspondence course was also available.[4] Today, most of the 18 chiropractic schools in North America require a minimum of two years of college before entrance and have a curriculum lasting four years. There are no state-operated schools; all are privately owned. Preadmission requirements at most chiropractic schools include six semester hours each of biology, inorganic chemistry, organic chemistry, physics, and English; three semester hours of psychology; and 15 semester hours in humanities. A minimum grade point average (GPA) of 2.0 is typically required, and the undergraduate GPA is approximately 2.9 on admission.[5]

Chiropractic education includes instruction in basic sciences such as anatomy, biochemistry, pathology, microbiology, and histology, in addition to chiropractic courses. Most chiropractic schools also teach physical diagnosis and courses in cardiology, pulmonology, obstetrics, dermatology, and other medical topics. These courses are usually taught by chiropractors, not medical specialists, and few chiropractic students have exposure to significant medical pathology seen in hospitals and medical clinics.[6] This deficiency in diagnostic training is compounded by the fact that chiropractors primarily treat musculoskeletal complaints, and it calls into question their ability to serve as competent primary care providers.

The basic tenet of chiropractic is the subluxation theory, which holds that:

1) displacements or subluxations of vertebra disturb nerve flow,

2) disturbed nerve flow is the source of disease and suboptimal health,

3) chiropractic methods identify and correct subluxations to restore nerve flow and health.[7]

Most chiropractors still subscribe to the subluxation theory to some

extent; many believe nervous system disturbances weaken the body's defenses, allowing disease factors such as bacteria to produce illness. Only one group, the National Association for Chiropractic Medicine, completely disavows the subluxation theory.[8]

Many chiropractors say subluxations result from birth trauma, fever, drugs, falls, stress, poor posture, and other factors.[2] Heart disease, cancer, asthma, allergies, hypertension, rheumatoid arthritis, osteoarthritis, upper respiratory infections, gastrointestinal disorders, psychiatric illnesses, bed-wetting, gynecologic disorders, immune deficiencies, tennis elbow, and carpal tunnel syndrome are some of the conditions attributed to subluxations in the chiropractic literature.[4]

Chiropractic manipulation is typically a short-lever technique in which the hands are placed on the spine over the site of the subluxation, and a high velocity, low-amplitude thrust is applied, often producing a popping sound.[9] Osteopaths, physical therapists, some medical doctors, and others may do spinal manipulation; however, the chiropractic subluxation theory differentiates chiropractic from treatments that manipulate the spine for reasons such as pain relief or increasing joint mobility. Another chiropractic technique is the use of a spring-loaded, plunger-like device called an activator to deliver the thrust.

Chiropractors use various x-ray marking systems with which they compare spinal x-rays to an "ideal" spine. Some use this to determine the number of manipulations needed to correct the subluxation—often one manipulation per millimeter of spinal displacement.[10] Some chiropractors believe in manipulating sites other than the spine, including the skull—a practice referred to as craniopathy. According to this theory, misaligned skull bones are the source of such maladies as deafness, blindness, paralysis, seizures, dyslexia, and mental retardation. Techniques used to manipulate the skull include hand pressure to various skull components and what is called "Bilateral Nasal Specific," in which balloons are inflated in the nasal cavities to move "misaligned" bones.[4]

Although manipulation is the main component of chiropractic, most chiropractors use other modalities as well. These include vitamin supplements, herbal products, animal glandular substances, acupuncture, iridology, colonics, and homeopathic remedies. Many chiropractors openly condemn and discourage not only scientific medical care but also well-established public health measures such as fluoridation, immunizations, and pasteurization.[11] Chiropractors who use physical therapy modalities, nutritional products, and who may do full-body diagnosis are referred to as mixers; those who do spinal manipulation exclusively are referred to as straights. The Federation of Straight Chiropractic Organizations (FSCO) issued a legislative alert in May 1993 that criticized mixers. The FSCO stated that the diagnostic abilities of mixers are inferior to medical doctors', since mixers "lack proper medical training, internships, and hospital experience."

Physicians, Chiropractors, and Antitrust

In 1976, five chiropractors filed antitrust lawsuits against the American Medical Association and others charging them with conspiracy to destroy chiropractic. In 1987, Federal Court Judge Getzendanner ruled against the AMA and ordered a permanent injunction forbidding the AMA from restricting or regulating any individual member or institution from making an individual decision whether or not to professionally associate with chiropractors or chiropractic institutions.[12] The ruling did not limit the right of the AMA to take a position on chiropractic, and it was not an endorsement of chiropractic. The court specifically declined to pronounce chiropractic valid or invalid. In fact, the judge stated, "At the time the Committee on Quackery was operating [1963-1974], there was a lot of material available to the AMA Committee that supported its belief that all chiropractic was unscientific and deleterious." The judge also stated that she believed the AMA was motivated in its actions by the public's best interests. The decision was, therefore, not a scientific validation of chiropractic but a legal interpretation and application of the Sherman Antitrust Act. Physicians and medical societies clearly retain the right to educate consumers regarding chiropractic.

Chiropractic in Minnesota

In 1989, Minnesota had one chiropractor per 2,600 persons, the highest per capita rate in the country.[13] Currently, there are more than 1,700 licensed chiropractors in the state. Two Minnesota hospitals grant privileges to chiropractors: Mercy Hospital in Moose Lake and Cook County North Shore Hospital in Grand Marais. The Minnesota State High School League permits chiropractors to do athletic physical examinations.

The scope of chiropractic in Minnesota is defined in the Minnesota Statutes, chapter 148, and Minnesota Rules, chapter 2500. "Chiropractic is defined as the science of adjusting any abnormal articulation of the human body, especially those of the spinal column, for the purpose of giving freedom of action to impinged nerves that may cause pain or deranged function." According to state law, chiropractors can also use physical therapy modalities and can manipulate the skull. In addition, they can counsel patients "on dietary regimens, sanitary measures, occupational health, life-style factors, posture, rest, work, and recreational activities," according to state law. Chiropractors can also recommend various nutritional supplements and sell them to patients out of their offices. Despite objections by physical therapists, dietitians, and medical doctors, a state administrative judge's decision changed the state rules, permitting chiropractors to utilize physical therapy, acupuncture, and nutritional counseling in their practices.[14]

Research on the Benefits of Chiropractic

Several recent studies have looked at spinal manipulation for low back pain. A 1991 RAND study reviewed 67 articles and nine books on spinal manipulation. The study found sup-

port for manipulation in patients with low back pain without signs of lower limb nerve root involvement from 22 available controlled studies.[15] Of these studies, only four were chiropractic in origin; the rest were done by osteopaths, physical therapists, and others.[16] RAND specifically addressed the appropriateness of spinal manipulation (not chiropractic) for low back pain and not other conditions. It did not compare spinal manipulation to other therapies for low back pain in terms of cost or efficacy.[17] Chiropractic funded the study, and four of the nine evaluators were chiropractors.[16]

In 1991, the *British Medical Journal* published a meta-analysis that evaluated manipulation for back and neck pain and concluded that, although some results are promising, the efficacy of spinal manipulation has not been convincingly shown.[18]

In 1992, the *Annals of Internal Medicine* published an extensive review of the available literature on spinal manipulation for low back pain and concluded, "Spinal manipulation is of short-term benefit in some patients, particularly those with uncomplicated acute low back pain." The study did not recommend spinal manipulation for sciatic nerve root irritation because it could potentially cause neurologic complications; furthermore, the study did not recommend spinal manipulation for chronic low back pain, citing insufficient supporting data. The study found no evidence that manipulation physically influences herniated nucleus pulposus, nor is it of proven value for spinal stenosis or spondylolisthesis. The study also noted that the optimal frequency and duration of manipulations is unclear from available literature, as is the complication rate.[19]

A 1990 low back pain study published in the *British Medical Journal* compared private practice chiropractic treatment to outpatient public health service hospital treatment, which consisted primarily of manipulations and mobilizations performed by physical therapists in patients without signs of nerve root compression. Chiropractic treatment was found to be more effective in subgroups of patients with chronic or severe pain but not in those patients without a history of low back pain. Chiropractic treatment cost 50% more and was continued for 30 weeks versus 12 weeks for hospital-based outpatient treatment. The authors stated that difficulty with access to hospital treatment early in the study may have influenced outcome in favor of chiropractic.[20]

Several studies have collected data on chiropractic and medical provider services in workers' compensation injuries. None of these studies controls for severity of injury, and therefore, the results are not directly comparable.[17] A 1990 Minnesota Department of Labor and Industry study found that the median cost per back injury was $335 for those treated with chiropractic and $288 for those receiving medical care. The median duration of therapy was 32 days for chiropractic and 13 days for those treated medically. The median number of work days lost per back injury was seven for chiropractic and 10 for medical therapy; however, the medically treated group included those with severe injuries requiring hospitalization or surgery.

Reports in the chiropractic literature have found little evidence that manipulation is effective for bedwetting,[21] asthma,[22,23] COPD,[23] or hypertension.[23] According to "Principles and Practice of Chiropractic," no published randomized studies suggest spinal manipulation is efficacious for visceral disorders.[23] A review of the chiropractic literature using Chirolars, a computerized chiropractic reference service, revealed no controlled studies on spinal manipulation for carpal tunnel syndrome or allergies. Although some studies on spinal manipulation for headaches and neck pain have shown short-term value, cervical manipulation carries an unacceptable risk-benefit ratio and should be avoided.[23,24] The chiropractic literature has questioned the value of spinal x-rays in determining subluxations and their relevance to the benefits of manipulation. A highly regarded research review completed in 1993 by a number of chiropractic scholars entitled "Guidelines for Chiropractic Quality Assurance and Practice Parameters: The Mercy Center Consensus Conference" noted that "To be a valid outcome measurement, misalignments should theoretically reduce with therapy," and "there are few experimentally controlled studies indicating that manipulations/adjustments are the reasons for changes in misalignment seen over time." Regarding reported changes in spinal alignment following manipulations, the report noted, "The clinical relevance of small changes seen in vertebral position is scientifically controversial."[25] Simple changes in patient position, radiographic aberration, intra-observer error, and biologic variation are as likely to cause radiologic changes as is chiropractic manipulation.[26] Blinded studies failed to find significant changes on post-manipulation spinal films in patients with neck and low back pain.[27,28]

Commentary

The subluxation theory is not supported by available objective scientific data. This position is supported from several perspectives. Chiropractic stands alone in its recognition of the subluxation theory; basic science textbooks in anatomy and physiology do not recognize subluxations or their purported effects. A 1990 Japanese Ministry of Health report on manipulation therapy found chiropractic to be outside the scientific mainstream. The report states that chiropractic methods are "not based on the knowledge of human anatomy but are subjective and unscientific."[29] The term subluxation is ambiguous, and there appears to be no consensus on a definition; some chiropractors say subluxations are anatomic, others say they are functional, and others use the more elusive and cryptic "vertebral-subluxation complex." This lack of consensus reflects the fact that chiropractic is a philosophically fragmented profession that spans a continuum from those who are attempting to use scientific methodology to determine where spinal manipulation is beneficial, to those who cling to the pre-scientific dogma of Palmer and claim to be exempt from the scientific-medical "paradigm."

The various methods to determine the presence or location of chiropractic subluxations have largely not been scientifically validated. Specifically, thermography, surface EMG, Moire topography, bilateral weight distribution scales, palpation of bony landmarks, and various spinal x-ray marking systems have not been subject to controlled studies.[6,7,9,10,25] Radiological, anatomic pathological, and EMG studies do not support the concept that subluxations cause spinal nerve root compression.[7,23,25,30] In "Principles and Practice of Chiropractic," Triano notes that "Little clinical or scientific evidence exists to suggest that direct nerve compression plays an important role with functional spinal lesions" (his term for subluxations), and also, "Little scientific information is presently available to resolve the questions of impact on human health that functional spinal lesions have."[23]

No research shows that chiropractic manipulation is an effective form of preventive therapy.[25] Again in "Principles and Practice of Chiropractic," Bronfort states, "It is generally agreed that long-term benefits of spinal manipulative therapy have not been convincingly demonstrated," and that there is no scientific evidence suggesting spinal manipulation is effective in preventing recurrences of neuromuscular disorders.[23]

Available research suggests that spinal manipulation has therapeutic value for some patients with low back pain. The therapeutic mechanism has not been determined, although altering local joint physiology and restoring mobility to fixed joints are possibilities. Low back pain is also a self-limited disorder that resolves regardless of therapy in 90% of patients at two months, which parallels typical chiropractic treatment protocols.[10] Placebo effect has not been thoroughly evaluated in spinal manipulation and likely contributes to its efficacy. Placebo effect is undoubtedly enhanced by the "laying on of hands" and the popping sound produced by manipulation. The sound, which can be used to convince a patient that a bone has been put "back in place," is attributed to the sudden separation of two joint surfaces held in close contact by fluid attraction in a vacuum.[9]

Some disturbing trends exist in chiropractic health care. For example, some chiropractors have a penchant for many forms of "alternative" health care that are unsubstantiated; often they become "experts" in these areas, which can include applied kinesiology, homeopathy, reflexology, acupuncture, herbal medicine, and supplement-oriented nutrition.

What is most disturbing is the promotion of chiropractic manipulation as beneficial for certain conditions when either no such evidence exists or well-designed chiropractic research demonstrates little or no efficacy using manipulation. This is particularly troubling in pediatrics, where chiropractic has launched an aggressive marketing effort, according to the *Wall Street Journal*.[31] One chiropractic brochure is quoted as saying, "If your child has a fever and acts abnormally, call your chiropractor." An article on "How to Build a Children's Practice" tells chiropractors to ask adult patients to bring in their children and "find a problem." The *Wall Street Journal* also cites two cases of mastoiditis, one of which resulted in deafness following chiropractic care for otitis media. This marketing effort is being carried out despite the fact that chiropractic students typically receive only brief classroom instruction in pediatrics with little patient contact.[32]

Chiropractors are also advocating manipulation on newborns for subluxations attributed to birth trauma and are promoting scheduled spinal adjustments for all children.[31] This is an obvious effort to get parents to believe maintenance chiropractic care should be as routine and accepted as dental checkups.

A publication entitled "Proceedings of the National Conference on Chiropractic and Pediatrics 1991" reviewed the chiropractic theory of otitis media and other conditions. Chiropractors theorize that irritated cervical spinal nerves cause the sternocleidomastoid muscle to spasm, blocking lymphatic flow from the eustachian tube. The author notes, "No research studies have yet been published to validate this hypothesis," and there are no controlled studies that suggest spinal manipulation prevents or resolves otitis media.[33] A 1986 U.S. Department of Health and Human Services report also concurred: "There also exist patterns of activity and practice which at best appear as overly aggressive marketing—and, in some cases, seem deliberately aimed at misleading patients and the public regarding chiropractic care."[34] The previously noted Japanese Ministry of Health report stated that the "chiropractic boom" is due to "commercially based, extravagant advertising and the exaggeration of effectiveness."[29]

Conclusion

Spinal manipulation is a therapeutic option that physicians may consider in the treatment of low back pain, particularly when measures such as rest, ice, heat, prescribed exercise, and analgesics are not successful. Although the group of patients most likely to benefit has yet to be defined, it would appear that a short course of manipulation for those with acute low back pain without pain radiating into the legs might benefit. Spinal manipulation for nonmusculoskeletal conditions is contrary to current scientific evidence and is not supported by available quality studies. Chiropractors should not be considered the equivalent of medical doctors in primary care, as their diagnostic training is inferior, and their therapeutic options are very limited and often unsubstantiated. Physicians should thoroughly understand the training and scope of practice of any particular chiropractor before deciding a referral is in a patient's best interest. In particular, physicians should inquire and evaluate whether a particular chiropractor subscribes to the subluxation theory, advocates prophylactic or "maintenance" manipulations in asymptomatic patients, or promotes chiropractors as primary care providers or child health experts. MM

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Attention Turns to Tort Reform

Liability relief may be in store for physicians under a variety of health system reform proposals in the works.

Theodore M. Thompson, J.D.

Tort reform is a perennial topic and one that arouses the passion of reformers and anti-reformers alike. Whatever the perspective, a new focus on medical liability reform has emerged as individual state legislatures, the president, and Congress seek to rein in health care costs. No one area of health care will provide the cure-all for what ails the American health industry, but similarly, no one area should be ignored in a comprehensive reform of our $900 billion health care industry.

Cost of Medical Malpractice

Liability costs in the United States are five times greater than liability costs in such other countries as Germany, Great Britain, Australia, France, and Japan.[1] In the much publicized Lewin-VHI study on defensive medicine, the "middle-range estimate of potential defensive medicine *savings* from comprehensive malpractice reform is $4.3 billion in 1994 and a total of $35.8 billion between 1994 and 1998"[2] (emphasis added). The federal government estimates that the costs associated with medical malpractice premiums amount to $6 billion per year. Some may argue that, as a percentage of the overall cost of health care, these amounts are not significant. However, we need to remember that these *billions* are real dollars, and, if redirected toward providing health insurance to the uninsured, would cover more than 3.5 million Americans.*

The other cost that is so often ignored in discussions of medical malpractice is the personal and professional toll malpractice actions take on physicians. A number of allegations against physicians are without merit but, nonetheless, cause physicians to endure a great deal of personal anguish, professional review, and, sometimes, public humiliation. Personally and professionally committed to the practice of quality medicine, and dedicated to the improvement and preservation of human life, physicians whose abilities are put into question by allegations of malpractice face a great deal more than the possibility of financial loss.

Attitudes and Opinions

In a Greenberg-Lake survey of Minnesotans about what should be done to help contain health care costs, 50 percent of respondents said that jury awards in medical malpractice suits should be limited.[3] A *Wall Street Journal*/NBC News poll found that 76 percent of Americans support limits on damage awards for medical malpractice.[4] Eighty-four percent of risk managers surveyed by Alexander and Alexander Services, Inc., felt that "spiraling health care costs and caps on non-economic and punitive damages" are of above-average concern. Modification of the joint and several liability doctrine was cited by 78 percent as an above-average concern.[5] Surveys and polls appear weekly and the results mean different things to different people, but it is clear that reform of the civil justice system is on the minds of many in business, industry, and the general public.

Medical Liability Reforms: Current Activity

Numerous medical liability reform proposals are being considered by Congress and state legislatures. President Clinton's Health Security Act proposes modest reforms, such as capping attorney fees at one-third of awards, using plan-based alternative dispute resolution, requiring certificate of merit before a suit can be brought, allowing evidence of collateral sources, and mandating periodic payments. Clinton has also proposed an "enterprise liability" pilot in which states would receive federal funding to establish a demonstration project to determine whether shifting liability for medical malpractice from the individual physician to the health plan, or "enterprise," would result in quality of care improvements, re-

*This number is derived by using the $7 billion cost of defensive medicine estimated in the Lewin-VHI study (see reference 2) and dividing it by Lewin-VHI's estimated per-family (two parents, one child) cost of health coverage, $5,975/year, under President Clinton's proposal. According to these calculations, money now spent on defensive medicine could instead pay for health insurance for 1,188,285 families or 3,565,854 individuals.

duced defensive medicine, and better risk management. A second pilot has also been proposed to determine the impact of the application of practice guidelines in medical malpractice liability actions.

Medical liability reform has worked in California. In 1975, California's MICRA (Medical Injury Compensation Reform Act) capped non-economic damages, limited attorney contingency fees, eliminated the collateral source rule, and allowed for periodic payment of damages. In the early 1970s, California medicine was in crisis. The number and size of lawsuits against providers had grown dramatically, and malpractice premiums were increasing by 300 percent to 500 percent per year. Malpractice insurance carriers were leaving the state, as were physicians who were unwilling to work in such a hostile climate. In responding to the crisis, all parties concerned negotiated and passed the MICRA legislation. The impact was great. In 1975, California had the highest malpractice premiums in the *world*. In 1990, California premiums were one-half or one-third of those in states that had not enacted MICRA-type reforms. By 1991, California ob/gyn premiums ranked 15th in the United States, internal medicine premiums 17th, and surgical premiums 19th.[6] MICRA reforms worked in California, and they have worked in other states.

Minnesota has seen reform activity as well. In the mid-1980s, a number of provisions were passed into law resulting in more controlled malpractice premiums. Lower premiums are also a result of the continual improvement in the practice of medicine by Minnesota physicians. Aggressive risk management audits, continuing medical education, and an unyielding dedication to the highest quality care have been crucial for controlling medical malpractice insurance rates.

More recently, during the 1993 legislative session, Rep. Wayne Simoneau, DFL-Fridley, and Sen. John Hottinger, DFL-Mankato, introduced an MMA-sponsored tort reform bill that has components similar to California's MICRA law. Under the Simoneau/Hottinger proposal, a cap of $250,000 would be placed on non-economic damages; attorney fees in medical malpractice cases would be limited by a sliding scale and could be based only on economic damages; access to the provider for both defense and plaintiff would be equalized; and liability would be apportioned based on the percentage of fault. Other pending tort bills include changing the practice parameter absolute defense; providing limited immunity for volunteer athletic trainers and physicians; creating a "state of the art" defense for medical products; prohibiting the award of punitive damages for federal FDA-approved products in certain cases; requiring that punitive damages be reasonably related to compensatory damages; and requiring that punitive damages be paid to the state of Minnesota, instead of the plaintiff, for funding health care.

> "Physicians whose abilities are put into question by allegations of malpractice face a great deal more than the possibility of financial loss."

Less favorably viewed by the Minnesota Medical Association are efforts to change the statute of limitations in Minnesota in a manner that would create increased risk exposure, thereby resulting in more claims, more lawsuits, and, ultimately, higher malpractice premiums, which would invariably lead to higher health care costs. A change at this time appears inconsistent with state and federal efforts to contain costs. A proposed bill, known as the "discovery rule," would change the statute of limitations, which is currently two years from *date* of injury, to two years from *discovery* of the injury, or with due diligence, the date at which the injury should have been discovered. While the current statute appears straightforward and rigid, it has not operated as such. Minnesota courts have repeatedly allowed claims beyond the two-year period under a variety of legal theories, including "continuation of treatment," in which the time clock begins to tick at the last date of treatment for the condition in question. The discovery rule bill had a hearing in the House Judiciary Committee, Civil Law Subcommittee, on December 2, 1993, along with six other medical-related tort bills. Last session, the discovery rule passed out of the Senate Judiciary Committee and was referred to the Health Care Committee, where it now awaits a hearing.

The 1994 legislative session is the second in the biennium and is expected to last only six or eight weeks. Because of the short session and the Legislature's expected focus on two top issues, ISN implementation and juvenile crime, it is impossible to determine what other major legislation will move.

Elements of Medical Liability Reform

With renewed attention turned to reforming the medical liability system as a means of controlling costs, it is helpful to understand the merits of individual proposals. Following is a survey of a number of tort reform concepts.

Caps on non-economic damages

Non-economic damages are defined as pain, suffering, inconvenience, disfigurement, and other non-pecuniary damages. A cap allows injured parties to receive compensation for all economic damages, such as medical expenses and loss of earnings, but limits recovery for intangible damages. Currently, 14 states limit non-economic damages, with caps ranging from $250,000 to $1 million. Eight states have chosen to cap both economic and non-economic damages, and four of those states have created patient compensation funds that provide additional insur-

Practice Parameters and the Absolute Defense

Too Good to be True?

A new Minnesota statute that offers physicians an absolute protection from liability may fall short of its promise. In part, the statute provides that "adherence to a practice parameter approved by the commissioner of health ... is an absolute defense."[1]

The bottom-line question is, if a physician follows a practice parameter that has been approved by the commissioner of health, will the physician truly be provided absolute protection from liability? As with many legal questions, the answer is a definite "maybe."

In assessing a given case, a number of issues must be considered. First, it is questionable whether the absolute defense protection is available in cases of delay in diagnosis, misdiagnosis, inappropriate application of a practice parameter, failure to obtain informed consent, battery or other intentional tort, or product liability. The statute affirmatively states that, in those cases, the standard or burden of proof remains the same.

Second, a physician may not want to claim the absolute defense. Why? Because in order for the physician to benefit from its protection, his or her attorney must prove that the physician complied, point-by-point, with the parameter, thereby bringing into evidence before the jury all activities related to the alleged malpractice.

Third, once the defense has made its case that the physician complied with the parameter, the plaintiff's attorney will have an opportunity to challenge the claimed adherence to the parameter. Under current statute, only the defendant may raise practice parameters as a defense, but once raised, it is fair game and the plaintiff may try to prove noncompliance. The statute also provides that the plaintiff may not bring evidence of departure from the parameter into court unless the absolute defense has been asserted.

To further muddy the waters, it is likely that a defense attorney will recommend use of the absolute defense in clear-cut matters only, not in complicated situations. For example, if a parameter states that women aged 45 and above should have an annual mammogram, and Patient A, who is 50 years old, has received a screening every year for the last five years, then it is clear that the physician was operating within the established parameter. Conversely, more complex parameters may not work as well; for example, parameters that describe when a physician should order a CT scan for headache may not be sufficiently concise for a defendant to use the defense.

> "The promised absolute defense protection is not the magic cure for what drives defensive medicine."

Also in question is whether a physician who adheres to a parameter can be charged with malpractice if it turns out that deviating from the parameter would have been more appropriate.

The clash over whether practice parameters are a strategy for improving outcomes and quality or just a reimbursement and cost-containment mechanism must not be overlooked, either. Use of practice parameters for quality improvement is not synonymous with their use for reimbursement purposes. Physicians may likely find themselves locked in a struggle over this, especially as multiple parameters are developed, not only by the health department, but by integrated service networks and health plans.

These are just a few issues surrounding the use of practice parameters. Many policymakers are touting parameters as one element of a cure-all for cost containment when, in reality, practice parameters may never be specific enough to provide protection nor broad enough to offer the flexibility essential for providing the highest-quality patient care. The Minnesota Legislature should be commended for taking a bold and difficult first step in trying to provide some liability protection for physicians following practice parameters. More work needs to be done, though, to ensure that the intended protection will truly exist when a case arises.

The promised absolute defense protection is not the magic cure for what drives defensive medicine, but it is a concerted effort to address a key component of medical malpractice. *–TMT*

REFERENCE

1. Minn. Stat., Supp. § 62J.34, Subd.3(a).

ance beyond that guaranteed by the defendant's malpractice insurance policy.[7]

Attorney fee limitations

Plaintiff's attorneys are generally paid on a contingency-fee basis, and the percentage of the fee is determined between the attorney and client unless a statute provides otherwise. The fee paid under this arrangement is generally one-third of the award, although the rate may be higher or lower depending on the case and its complexity. Minnesota has no statutory restriction on fee arrangements. Twenty-two states have some sort of limitation on attorney fees, including sliding-scale contingency fees, maximum percentages, and court review of reasonable rates.[7] The theory behind limiting what attorneys are paid is that an attorney will only take meritorious claims, thereby reducing the incidence of frivolous lawsuits. President Clinton has proposed a cap on attorney fees, but unfortunately, the cap is at one-third of the award; therefore, Clinton's proposal essentially preserves the status quo.

Pretrial screening

Pretrial screening panels (generally a physician, legal professional, and a lay person) are also intended to prevent frivolous lawsuits. Depending on the state, the screening panel decisions can be either voluntary or mandatory. Twenty-two states currently have some form of pretrial screening, although six state courts have overturned pretrial screening laws on the ground that they violate state constitutional guarantees of a right to trial, and five states have repealed pretrial screening statutes.[7]

Collateral source offset

Historically, compensation from other sources has been excluded from trial as evidence that an injured plaintiff had been compensated. This "collateral source rule" is rooted in English and American common law, but increasingly it is being dropped by states. Since 1986, 20 states have changed the collateral source rule, and 28 states currently have an offset provision so a plaintiff does not receive a "double recovery," first from health insurance, disability insurance, or other sources, then from a jury award in a medical malpractice case. The essential argument in favor of allowing evidence of collateral sources is fairness; an injured plaintiff should be compensated adequately but should not be able to gain a "windfall" from the injury.

> "MICRA reforms worked in California, and they have worked in other states."

Joint and several liability

The rule of joint and several liability means that when two or more defendants are liable for a plaintiff's injury, each of them is liable for the entire amount of damages, regardless of their individual responsibility. This can result in very unfair outcomes for a minimally responsible defendant when the primarily responsible defendant does not pay because of insolvency or lack of insurance or because he or she is outside the jurisdiction of the court. According to the American Tort Reform Association, more than two dozen states have reformed the rule of joint and several liability since 1985. Six states have completely abolished it, other states have limited its applicability. In Minnesota, a person who is 15 percent or less at fault is liable for a percentage of the whole award no greater than four times the percentage of fault.[8] While better than a pure joint and several rule, Minnesota's formula does not fully address the inequity resulting when a defendant with minor responsibility ends up bearing the heaviest burden of a verdict.

Claim certification

In order to bring suit for medical malpractice in Minnesota, a plaintiff must provide the defendant with an affidavit stating that the facts of the case have been reviewed by an expert and that, in the opinion of the expert, one or more defendants deviated from the applicable standard of care, thereby causing injury. Within 180 days after the lawsuit has been filed, an affidavit signed by both the plaintiff's attorney and the expert listed in the affidavit must be served upon the defendant. The affidavit must include the identity of experts to be called to testify, the substance of the facts and opinions to which the expert is expected to testify, and the grounds for each of the expert's opinions.[9] A set of uniform interrogatories has also been established.[10]

Periodic payment of future damages

Once a damage award has been determined, a method of payment has to be established. Payment can occur as a single lump sum or periodically over a set time frame. Periodic payment of future damages diminishes the impact of large damage awards, allows insurance companies to pay awards as expenses are incurred, lessens the net cost of malpractice awards, and provides structure to meet the financial needs of injured parties. Sixteen states allow for, but don't mandate, periodic payments. Fourteen states mandate periodic payments of future economic damages if damages exceed a threshold (generally $100,000 to $250,000).[7]

Alternative dispute resolution

Alternative dispute resolution, known as ADR, has become a growth industry over the past decade. Mini-trials, arbitration, mediation, med-arb, mediated settlement, consensual special magistrate, summary jury trial—these are just a few ADR mechanisms. Depending on the conflict, ADR is a vital tool in resolving problems without resorting to the overcrowded court system. Nearly every tort reform proposal in Washington—Democratic or Republican—has some ADR requirement to it. In Minnesota, litigation involving amounts in excess of $7,500 in controversy may be directed into nonbinding ADR by the presiding judge,[11] and last year the Minnesota Supreme Court released rules related to state-

wide ADR. The rules require the use of nonbinding ADR in all civil cases, except for good cause shown by the presiding judge.[12] The Center for Public Resources recently released a survey of health industry dispute resolution identifying numerous areas in which ADR would work well within the health care field and provide substantial cost savings.[13]

In medical malpractice it is far from certain that ADR truly saves money and avoids litigation. Flexibility should therefore be maintained and mandates avoided. A major problem with ADR is that once the process has been concluded, the decision is not binding unless the two parties agree to make it binding. If either party dislikes the outcome, litigation ensues and the result is an added layer of procedures and increased cost. Voluntary ADR mitigates this since both parties have assessed their own situation in advance and have individually decided to pursue ADR. Another handicap for ADR use in medical malpractice cases is the very nature of medical practice. Unlike relatively clear-cut contracts, warranties, employment provisions, and other arrangements that can lead to disputes and end up in arbitration, the practice of medicine is an inexact art wherein nearly every case presents its own unique problems. Physicians pursue a course of treatment based on their best professional judgment. Because of the complexity of the human body, there are no absolutes when treating a patient. Consequently, not all medical malpractice cases are conducive to ADR.

Conclusion

The health reform landscape in Washington is taking shape, and Minnesota reforms are entering year three. Medical liability reform in California worked because of its comprehensive nature. If Congress and the president are sincere in their desire to provide liability relief for physicians, then there is much work to be done on the president's plan to provide comprehensive reform. Hopes for real reform were heightened recently when First Lady Hillary Rodham Clinton declared that President Clinton will not "stand in the way of the Congress" if it comes up with a malpractice reform package that differs from his own.[14] The debate has begun in earnest. MM

Ted Thompson is legislative counsel for the MMA and staffs the Professional Liability Committee. Before joining the MMA he served for three years as deputy director for former Sixth District U.S. Rep. Gerry Sikorski.

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Where Medicine Meets the Law

Knowledge of the law as it applies to physicians is good medicine.

David C. Herman, M.D.

In a recent *Minnesota Medicine* Perspectives article, a physician chronicles the anger, fear, and sense of betrayal she experienced during a malpractice lawsuit ("Malpractice Nightmare: Good Medicine Didn't Protect Me," November 1993). In the essay, she admits that her emotions have kept her from practicing medicine as she would prefer. In my opinion, if the author had been more familiar with malpractice law, she would have avoided much stress during her lawsuit. Knowledge of the law as it applies to physicians is good medicine, and I would like to offer some guidance to those physicians who are interested in learning more about the laws that directly affect us.

Whom should I examine first, you or your lawyer?

We physicians often feel that we are singled out to bear the brunt of society's wrath, and many physicians falsely believe that medicine is the only profession restricted by the laws and attitudes of society. One need only to talk to a farmer, a small businessperson, or a waiter to expose the fallacy of this belief. One will hear stories of common farm chemicals being classified as hazardous waste, workers' compensation insurance rates exceeding 50 percent of payroll, and income tax paid for tips never received. No one is immune to the expanding scope and complexity of the law.

As physicians, we value and are valued for our rational response to extremely stressful situations. Why is it, then, that a physician who can run a code flawlessly in a life and death situation seems to fall apart when confronted with a lawsuit? The answer to this question is complicated and multifaceted, but I believe a large part of the reason is a lack of knowledge. A rational response to stress requires knowledge of what is required to resolve the situation. We are prepared to deal with a code because of our vast knowledge of the subject, based on years of training and experience. We must become more knowledgeable about the laws that affect us daily so that we can avoid unwanted situations and effectively deal with those situations we cannot avoid.

When I encourage physicians to become more familiar with the laws that pertain to them, I typically receive one of two responses. The first is, "I went to medical school to practice medicine, not to law school to practice law." This attitude is based on the false assumption that medicine and law are mutually exclusive. As we know from personal or anecdotal experience, law and medicine are intertwined, and woe to the physician who discovers this fact unprepared. The second response is, "That subject wasn't covered in medical school, and I certainly don't have time to learn it now." This response often comes from physicians who graduated from medical school when penicillin and sulfa were the only antibiotics available, and yet, these physicians can name all the new cephalosporins and their indications and dosages. Obviously, these doctors have no problem assimilating new information they feel is valuable; however, they apparently feel that acquiring even a limited knowl-

edge of the law is not worth a few hours of their time.

Most physicians should be familiar with 1) malpractice law, 2) rights and responsibilities in dealing with the Board of Medical Practice and the governing boards of hospitals and clinics, 3) the National Practitioner Data Bank, 4) employment law, and 5) the Americans With Disabilities Act. This is not an exhaustive list, but in my experience, it covers about 90 percent of all legal matters a physician might encounter.

The most obvious area of law physicians should understand is malpractice. When sued, physicians must work with their insurance companies to make sure their interests are being served. Encouraging the insurance company to do whatever is necessary to bring the case to a quick close is usually not the best approach unless some egregious, indefensible error has been committed. Even then, a conference with an attorney may determine a different approach. A small investment of time spent reviewing your rights now may prevent panic and wasted energy later. *Minnesota Medicine* published an excellent article, "What Happens in a Malpractice Action" (October 1992),[1] and I encourage every physician to read and file this article for possible future reference.

The Board of Medical Practice is the licensing body for physicians in Minnesota. State law requires that reports of all malpractice settlements, including those reached out of court, be forwarded to the board. In turn, the board is required by law to review these settlements for evidence of practice below the minimum standard of care. In addition, more than 1,000 complaints were filed with the board in 1992, so chances are high that physicians will hear from the board regarding a complaint sometime during their careers. All physicians have specific rights during a Board of Medical Practice investigation. A previous article in *Minnesota Medicine*, "The Board of Medical Practice and Its Disciplinary Process" (December 1991),[2] describes due process during board investigations. This article should be consulted and filed. (The board has since established a triage system for handling complaints, as described in the board's spring 1993 newsletter. For more information, call the board at 612/642-0538.)

The National Practitioner Data Bank collects and selectively distributes information on physicians. The information is collected through mandatory reporting procedures. Some of the actions that require a report are malpractice settlements, licensure sanctions by a medical board, actions against hospital privileges by a hospital, and actions by medical societies. For example, temporary suspension of hospital privileges for failure to sign charts can trigger a mandatory report to the National Practitioner Data Bank. Knowledge of the types of actions that require a report may help keep your name out of this database. I recommend consulting "Physicians Under Surveillance: The National Practitioner Data Bank" (*Minnesota Medicine*, March 1993).[3]

> "No one is immune to the expanding scope and complexity of the law."

Most, if not all, physicians work with colleagues and employees of either their own office or other medical facilities. Employee rights and responsibilities have become fertile ground for lawsuits. Sexual harassment and wrongful termination of employment are two areas of employment law about which all physicians should have at least a general level of understanding. Seemingly innocent comments at work may be grounds for a lawsuit or accusation (see "Sexual Harassment in the Workplace: How to Recognize, Investigate, and Prevent the Problem," *Minnesota Medicine*, May 1992).[4]

Knowing your rights as an employer or employee can also prevent future problems. The Americans With Disabilities Act provides certain rights to employees and patients concerning working conditions, facilities, and other specific rights (see "Disabilities Discrimination in Public Accommodations and Services: What Physicians Need to Know About the Law," *Minnesota Medicine*, November 1991).[5]

As stated earlier, perhaps the best way to prevent unnecessary stress in a given situation is to acquire knowledge ahead of time. The purpose of this editorial is not to provide the legal information physicians need, but rather to give examples of subjects all physicians should explore. We all know that it takes more than a strong knowledge of science to practice good medicine, and selective knowledge of the law as it applies to physicians certainly falls into the realm of good medicine.

The Minnesota Medical Association, through *Minnesota Medicine*, discusses legal issues monthly under the heading of *Medicine Law & Policy*. I would encourage physicians to take the time to explore this section of the journal. We must work with knowledge, not fear, to be our most effective. MM

David Herman is a consultant in ophthalmology at the Mayo Clinic in Rochester and is a former board member of the Minnesota Board of Medical Practice.

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The Monitor

News For Minnesota Physicians

Announcements

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1994 MMA Political Education Workshop

The future of medicine is being decided today. Don't sit back and watch it happen. Learn how to be an effective player in the political process.

The Minnesota Medical Association Political Action Committee and the American Medical Association will present a half-day political education workshop on Saturday February 19, 1994, from 8 a.m. to 1 p.m. at the Sheraton Midway Hotel in St. Paul. Political experts, including Michael Dunne, a Washington, D.C., political consultant who works closely with the AMA, will conduct the workshop.

- Find out why physician grassroots political action is so effective.
- Understand the state and federal legislative process.
- Learn more about state and federal political issues.

There is no charge for the seminar, but space is limited. To register, call Wendy O'Donnell at the MMA, 612/378-1875 or 800/999-1875.

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Call MMA's Fax on Demand Hotline

Call 1-800-DIAL-MMA and ask for current information about MMA activities to be sent directly to your fax machine. The MMA's recorded message will tell you what information is currently available and how you can obtain it.

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Watch for the *Monitor In Brief* on February 15.

Preview of the 1994 Minnesota Legislature

The legislative session is fast approaching. On February 22, the 1994 Minnesota Legislature will reconvene for the second half of the biennium. Although this is supposed to be the short session, legislators may be at the Capitol as late as May. Committees will probably begin to meet in mid-March, and conference committees are expected to resolve differences in House and Senate bills in April.

Once again critical health care issues will be up for consideration. Health system reform bills such as the Minnesota Health Care Commission's plan to achieve universal coverage by 1997 and the Minnesota Department of Health's implementation plan for integrated service networks (ISNs) and the regulated all payer option (RAPO) will be the dominant issues. The Minnesota Medical Association will support efforts to provide health care coverage for all Minnesotans and will urge legislators to adopt a stable, broad-based funding source to pay for it. The association has taken a detailed position on the complex ISN/RAPO proposal (see page 37). The MMA's overall goal will be to press for a plan that will preserve Minnesota's current high quality of health care and improve access.

Legislators will also consider a number of other proposals that will have an impact on health care. The MMA Committee on Legislation, chaired by David L. Swanson, M.D., is in the process of developing recommendations to be forwarded to the MMA Board of Trustees. MMA policy will follow the direction set by the MMA House of Delegates.

A preview of the health care legislation expected this session follows.

Anti-Violence Proposals

A number of measures aimed at reducing violence will be proposed by the Attorney General's office and DFLers in the House and Senate.

Several proposals target education and early intervention as a way of preventing crime. Legislators will ask for money to fund previously enacted school programs on violence prevention, to expand preschool violence prevention and parenting programs, expand D.A.R.E. (Drug Abuse Resistance Education), implement a pre-kindergarten through 12th-grade curriculum to prevent gun violence, and implement a middle school curriculum focusing on gangs and violence prevention.

Proposals aimed at "getting guns away from kids and off the streets" would prohibit young people under the age of 21 from buying handguns and assault weapons, make it a felony for anyone younger than 21 to carry an assault weapon, make it a felony to sell a handgun or assault weapon to anyone younger than 21, prohibit violent juvenile offenders from owning a gun for 10 years after discharge from sentence, and set mandatory minimum sentences for drive-by shootings.

There will also be requests for more money to help battered women and children, for sexual assault prevention and general crime victim

Preview continued on page 39

Viewpoint

Gail L. Gamble, M.D.
Chair, MMA Board of Trustees

MMA Prepares for Successful 1994 Session

At our meeting January 8, the Minnesota Medical Association Board of Trustees studied health system reform issues that will guide the association during the challenging 1994 legislative session. We considered two crucial proposals that will come before the Legislature this session: 1) the Minnesota Health Care Commission's plan to achieve universal health care coverage by 1997, and 2) a proposal drafted by the Minnesota Department of Health (MDH) setting forth a plan to implement integrated service networks (ISNs) and the regulated all payer option (RAPO).

The MMA Board supported the goal of the Minnesota Health Care Commission's plan to achieve health care coverage for all Minnesotans by 1997. While we would like to move more quickly, we support the plan's insurance reforms as well as the mandate that everyone have health insurance. We support a standard medical benefit set and will urge the Legislature to implement it as soon as possible rather than waiting until 1997. We support the recommended 40 cent increase in the cigarette tax each year for five years to subsidize premiums for those who can't afford health insurance, and we also recommend an increase in the alcohol tax. But higher "sin taxes" won't raise enough money to fund coverage for the uninsured. There aren't enough dollars in the MinnesotaCare program now to fund its benefits. The MMA will continue to advocate a broad-based funding source to pay for universal health care coverage.

The MMA Board developed a detailed position on the current draft of MDH's plan for implementing ISNs and RAPO. The MMA has been working on these critical issues for a long time. While the Minnesota Department of Health developed successive drafts of its plan for ISNs and RAPO, the MMA has been negotiating through our representative on the Minnesota Health Care Commission, Jasper M. Daube, M.D., and also has submitted written recommendations and proposals to the MDH and the commission. As *The Monitor* goes to press, we are still trying to achieve our objectives through negotiations prior to the legislative session.

Minnesota physicians have serious concerns about provisions in MDH's current draft that would erect barriers to the formation of small, regional ISNs. The plan's proposed financial solvency requirements for ISNs are higher than many other states' HMO requirements, and there is no phase-in provision that would allow an ISN to gradually build up reserves. The plan's proposal to set 10 large geographic service areas would prevent the formation of any ISNs that couldn't cover a large region.

Barriers to the formation of local ISNs are contrary to the intent of the MinnesotaCare Act of 1993, which states that the rules "must permit a variety of forms of ISNs to be developed in rural areas in response to the needs, preferences and conditions of rural communities."

Originally, the state intended to allow room for innovation and to preserve the opportunity for new systems to develop. The MMA supports giving ISNs enough flexibility to allow experimentation by physicians and other providers. ISNs should be encouraged to find better, more efficient ways to deliver health care and to respond to the needs of their own communities. Under MDH's second draft, these goals will not be met. The MMA urges a return to legislators' original intent to allow flexibility, innovation, and responsiveness to the local community.

The MMA will also press for a level playing field for ISNs and RAPO. Both systems should provide adequate reimbursement for physicians. The RAPO fee schedule, set by a state agency, will be a key issue. We are pleased that the current RAPO plan would set the same fee schedule throughout the state. The MMA has long believed that physicians in rural areas and those in metropolitan areas should receive the same pay for the same service. The RAPO fee schedule will be determined by multiplying the RVU (relative value unit) by a conversion factor set by the state. Physicians must be at the table when this conversion factor is set. This decision will determine whether or not RAPO will be a viable alternative to joining an ISN.

If you would like to find out how to support the MMA's efforts at the Legislature, please contact David Renner, MMA director of state legislation, or Molly Sigel, associate director of state legislation, at 612/378-1875 or 800/999-1875.

MMA Meets With St. Paul Editorial Board

The MMA met with the editorial board of the *St. Paul Pioneer Press* January 12 to express the MMA's support for the goal of universal health care coverage for all Minnesotans and to discuss our concerns with the implementation plan for ISNs and RAPO. Gail L. Gamble, M.D., chair of the Board of Trustees, A. Stuart Hanson, M.D., chair of the Guaranteed Benefits Task Force, C. Randall Nelms, M.D., president of the MMA, Mark Vukelich, director of communications, and Paul S. Sanders, M.D., chief executive officer of the MMA, represented the MMA at that meeting. The MMA has also issued a statewide op/ed on universal coverage.

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Rural Health Care Summit '94: Community Solutions

A two-day rural health care conference will be held February 10 and 11 at the St. Cloud Civic Center. Featured speakers and panelists include Lois Quam, senior adviser of the White House Task Force on National Health Reform; Jeff Human, director of the Federal Office of Rural Health; Carl (Chuck) Lofy, Ph.D., a national speaker and consultant; and Ann Wynia, former commissioner of the Minnesota Department of Human Services and former majority leader of the Minnesota House of Representatives. The summit is sponsored by the Minnesota Nurses Association, the Medica Foundation, the Minnesota Association of Colleges of Nursing, the Minnesota Extension Services Project Future and the Hubert H. Humphrey Institute of Public Affairs, the University of Minnesota Hospital and Clinic, and the Minnesota Center for Rural Health. For more information, call the Minnesota Nurses Association at 612/646-4807.

MMA Supports Goals of Universal Coverage Plan

The Minnesota Medical Association Board of Trustees reaffirmed its commitment to universal coverage and discussed the Minnesota Health Care Commission's Universal Coverage Plan at its January 8 meeting. The plan includes recommendations for phasing in insurance reform, reducing non-financial barriers to care, implementing a minimum medical benefits set, increasing funding for the MinnesotaCare program, and making health insurance mandatory. The MMA believes that reforms will only work if everyone is required to have insurance. An adequate broad-based funding source is necessary to subsidize coverage for those who can't afford it.

The Minnesota Health Care Commission had approved this plan, which was developed by its universal coverage subcommittee January 5. As directed by the 1993 MinnesotaCare legislation, the plan sets 1997 as the target date for achieving universal coverage. Physicians and consumers on the commission wanted to phase in insurance reforms more rapidly, while payers wanted to proceed more slowly. The current timetable represents a compromise. The commission approved the plan after Executive Director Michael Scandrett agreed to add a caveat that the section on insurance reforms, including the timetable, was subject to change based upon actuarial analysis. The big questions are whether the plan would erode the private market and how much it would cost. Scandrett said it was important to get as much coverage as possible through the private sector before expanding the public program, but he urged the commission to approve the plan now so they could put it into legislative language and start lining up authors. If changes in the dates are necessary, the commission will pass out an addendum later. Actuarial analysis is already underway. The MMA continues to urge that we proceed as quickly as possible.

Guaranteed Issuance and Renewability

Effective July 1995, all health plans would have to issue and renew health coverage for anyone willing to pay the premiums, but they could impose a waiting period, a pre-existing condition exclusion, quarterly premium payment requirement, and a 12-month coverage obligation. As of July 1, 1997, no conditions or restrictions would be allowed.

Guaranteed Portability

On July 1995, insured people could move from public programs to private health plans and from one plan to another offered by the same company without restrictions or exclusions. Effective July 1997, they would also be able to move between insurance companies.

Individual Coverage

Effective July 1, 1995, all insurance companies would be required to offer insurance to individuals as well as groups.

No Underwriting

As of July 1, 1997, underwriting based on health status or risk would be prohibited except for discounts for healthy lifestyles.

No Pre-existing Condition Restrictions

Effective July 1, 1997, insurance companies would not be able to impose pre-existing condition restrictions and exclusions except for new entrants into the health care system and people who waived group coverage when it was offered.

Community Rating

The amount of variation allowed in premiums would be reduced each year until July 1, 1997, when every-

Universal continued on page 36

Universal *continued from page 35*

one would have to be charged the same premium.

Mandatory Insurance

Beginning July 1997, all Minnesotans would be required by law to enroll in a health plan and to contribute to the cost of coverage, based upon their ability to pay.

Purchasing Pools

Effective July 1, 1994, Minnesota law would be changed to allow voluntary purchasing pools to form for the purpose of buying health coverage. The plan includes a number of requirements that purchasing pools would have to meet. By July 1, 1997, large purchasing pools would be available to all purchasers.

Consolidation

The Medical Assistance, General Assistance Medical Care, and MinnesotaCare programs would be merged into a single health care program for low-income Minnesotans. The Department of Human Services will ask the 1994 Legislature for authorization to seek federal waivers to permit the consolidation.

Once the proposed insurance reforms are in place, there would be no need for the state's high-risk pool, the Minnesota Comprehensive Health Association. MCHA would be closed to new enrollees beginning July 1, 1997.

Benefit Set

By January 1, 1997, a universal comprehensive benefit set would be the minimum standard of coverage for all Minnesotans.

Funding

The cigarette excise tax would be increased by 40 cents each year for the next five years.

Any remaining shortfalls in the MinnesotaCare program for 1994 and 1995 could be covered through the state's surplus revenues.

During 1994, the Minnesota Health Care Commission and state agencies should develop a plan to overhaul the existing system of government financing of health care. As much money as possible should be raised by taxing health risks such as tobacco. If additional money is needed, it should be raised by "broad-based taxes with appropriate offsets for low-income individuals." • • • • •

Solvency Is a Major Concern

• • • • • On January 5, the Minnesota Health Care Commission began to review the second draft of the Minnesota Department of Health's ISN/RAPO Implementation Plan and identified the areas of greatest concern to commission members. Solvency emerged as one of the most critical and divisive issues. "If one ISN goes broke, all the other ISNs must pay. This makes the reserve requirements very important," said George Halvorson, who represents the Minnesota HMO Council.

While payers argued that solvency requirements are too low, physicians argued that they are too high. Jasper M. Daube, M.D., representing the Minnesota Medical Association on the commission, said that the change to more stringent solvency provisions in the current draft "essentially says that providers aren't going to be able to become ISNs. It would lock in the big players, and lock out the others. We want to encourage smaller provider- and community-based networks."

Ray Christensen, M.D., the rural physician alternate representative, protested the elimination of the phase-in of the solvency requirements, a provision in the first draft that would have helped small ISNs during the start-up period. "There should be a mechanism to allow small providers and hospitals to play the game," he said.

Some commission members, including Halvorson, have proposed a waiver process that would allow small clinics and small hospitals that want to form an ISN to apply to the MDH for a waiver. The MDH could make case-by-case decisions on whether they had sufficient resources, monitor their performance, and step in if problems arose.

The MDH, however, opposes a waiver process. David Abrams, MDH director of legal and policy affairs, said, "Don't make the mistake of assuming that we are better able to predict the future than we are. We don't know how to pick the winners from the losers." He said that MDH supports setting appropriate solvency levels for everyone.

Abrams submitted a report to the commission that summarizes HMO solvency requirements in other states. The report shows that many states have solvency requirements similar to or lower—in some cases, *much* lower—than the solvency requirements proposed for Minnesota's ISNs. No states, with the possible exception of New Hampshire, have significantly higher requirements.

Daube, Halvorson, Richard Niemiec, the Blue Cross/Blue Shield of Minnesota representative, and others will form a subcommittee to come up with a proposal on solvency that would be an alternative to the MDH plan. Commission Chair Tom Swain predicted that members would end up lobbying separately on this issue since the commission is unlikely to reach consensus.

Board Approves Position on Practice Parameters

Meeting January 8, the MMA Board of Trustees approved a position paper on practice parameters, which was developed by the MMA Ad Hoc Committee on Quality Assessment and Data Utilization. An article on the MMA's position on practice parameters will be published in the June issue of *Minnesota Medicine*.

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Data Collection Partnership Is Formed

Minnesota Commissioner of Health Mary Jo O'Brien and the Minnesota Institute of Community Health Information (MICHI) have signed an agreement to act as the Minnesota Health Data Institute, a public/private initiative for the collection of information on health care costs, quality, and outcomes. Created by the 1993 MinnesotaCare legislation, the Data Institute is a partnership between the commissioner and a 20-member board of directors, representing health carriers and other group purchasers, health care providers, and consumers. The institute will implement a standardized patient satisfaction survey that will allow consumers to compare health plans, integrated service networks and the regulated all-payer option. "The ultimate goal is for health care consumers to be able to make wiser decisions," said O'Brien.

MMA appointees on the Data Institute are A. Stuart Hanson, M.D., and his alternate, Donald Asp, M.D., representing urban physicians, and Richard Dinter, M.D., and his alternate, Michael Murray, M.D., representing rural physicians.

The institute has been awarded a major grant from the John A. Hartford Foundation of New York to help support planning and implementation of the statewide data system.

MMA Urges MDH to Change ISN/RAPO Plan

On January 8, the Minnesota Medical Association Board of Trustees adopted positions on the second draft of the Minnesota Department of Health's (MDH) implementation plan for integrated service networks (ISNs) and the regulated all-payer option (RAPO), and immediately forwarded its recommendations to the MDH. These recommendations expand upon those outlined in the "MMA Integrated Service Network Position Paper," which was submitted to the state in November. (This position paper was summarized in the January *Monitor*.)

MMA Comments on ISN Proposals

Allow Flexibility

The MMA opposes excessively stringent net worth and asset requirements for ISNs. The current plan requires $1 million in net worth as well as a reserve deposit of $500,000. It allows 30 percent of the net worth requirement to be met through the participation of one or more accredited capitated providers. (An ACP is a capitated provider within the ISN who has contracted with the ISN to provide services without compensation to enrollees of an insolvent ISN for up to six months after the ISN has been declared insolvent.) Flexibility is needed to allow physicians and other providers to form small regional ISNs and encourage innovation.

Phase in Solvency Requirements

The MMA urges that a phase-in provision included in an earlier draft of the MDH plan be reinstated. A phase-in period would allow reserves to grow as the number of patients served by the ISN grows.

Don't Delay the Standard Benefit Set until 1997

The MMA urges the state to implement a standard benefit set for all plans, public and private, in 1994-95. The MMA Guaranteed Benefits Task Force will complete its report recommending a standard benefit set in time for it to be considered this session.

Add More ISN Geographic Service Areas

The 10 geographic service areas called for in the current draft are so large that they would discourage local, community-based ISNs, and would eliminate genuine competition. An ISN must serve the entire population of a geographic service area if it serves any part of it. Under this all-or-nothing rule, only networks capable of serving very large regions could operate if there were only 10 service areas in the entire state. The MMA urges the state to base district boundaries on existing local referral patterns.

Improve Antitrust Protection for Collaboration

The MMA recommends that current antitrust laws and enforcement policies be modified to provide more antitrust protection for collaboration among physicians and other providers. It also believes clearer federal and state exemptions are necessary.

Expand Fraud and Abuse Exemptions

The MMA recommends that the Minnesota law that exempts arrangements between ISNs and their participating entities from state anti-kickback laws be expanded to apply to other integrated delivery systems within ISNs or RAPO that are formed to coordinate care, improve quality, and reduce costs. A clinic without walls would be an example of such a system. The MMA encourages the MDH and the Minnesota Legislature to support anti-kickback exemptions for integrated delivery sys-

RAPO continued on page 38

RAPO continued from page 37

tems at the state and federal levels.

Allow Physicians to Bargain Collectively

The MMA recommends that physicians be authorized to organize and collectively bargain on issues such as quality, accessibility, and price of health care services. The MMA asks the MDH to support efforts to seek state and federal exemptions for collective bargaining.

Include Contract Protections

The MMA urges the state to include a provision stating that providers who sign a contract with a health carrier or other entity that later forms an ISN should not be bound to participate in that ISN unless the contract explicitly outlines a relationship with a future ISN, or unless there is an opportunity to renegotiate the contract, or by mutual consent of the health carrier and the provider. This provision should not apply to contracts between a health carrier and its salaried employees.

The MMA also proposes language that would protect physicians from pressure to enter exclusive arrangements. The MMA recommends that the state prohibit a health care entity from penalizing, or threatening to penalize, a physician for participating in or endorsing a competing network or entity.

Base Credentialing on Quality and Efficiency

The MMA urges the state to require that data used in physician credentialing, based upon "process of care and outcomes of care," include information on the severity of patient illness and co-morbid conditions. The MMA also recommends that language be added saying that "credentialing standards for providers should be based on the quality of medical care and the efficiency with which the care is provided."

Allow Physicians a Voice in Governing ISNs

The MMA strongly recommends that physicians be involved in developing health care delivery policies for ISNs. The ISN corporate structure should be similar to that of self-governing medical staffs in hospitals. Physicians participating in these ISNs must be able to comment, without fear of retaliation, on the plan's procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the network.

The MMA recommends that the requirement that at least 40 percent of the ISN board of directors be composed of consumers be adjusted and substantial physician representation on the board be required.

Encourage Collaboration on Public Health

The MMA supports increased collaboration between the public and private sectors in developing and achieving public health goals. The MDH plan proposes that ISNs be held accountable for achieving public health goals, and that they be evaluated by the Community Health Boards. The MMA recommends that, in order to further develop the collaborative relationship, ISNs should be represented on local Community Health Boards and on the state Community Health Services Advisory Committee.

Preserve Access for Special Needs Patients

The MMA supports the provision that would allow providers to apply to the commissioner of health for designation as an "essential community provider" (ECP) on the basis of a proven record of service to the impoverished or medically underserved populations that face language, ethnic, or other cultural barriers to health care or that have currently unmet health care needs. The MMA recommends extending the period during which ISNs could not exclude an ECP from any ISN in the area from the three-year period called for in the MDH plan to a five-year period. This extension would assure adequate services for special needs patients.

Encourage Purchasing Pools

The MMA supports the concept of community purchasing pools. In order to prevent a few extremely large pools from gaining excessive leverage, the MMA supports encouraging the formation of a number of different purchasing pools.

Include Risk Adjustment

Currently, the MDH draft does not adequately provide for risk adjustment. Jasper M. Daube, M.D., the MMA representative on the Minnesota Health Care Commission, is part of a subcommittee formed to develop a plan that would achieve the goals of risk adjustment, possibly through reinsurance measures.

Provide Grants for ISNs

The MMA urges that a provision be added that would give grants and technical assistance for starting up ISNs. This provision was part of the 1993 MinnesotaCare legislation but was omitted from both drafts of the MDH plan.

MMA Comments on RAPO Provisions

Eliminate RAPO Assessment

The MDH draft proposes that the state assess all-payer insurers for the value of not having to abide by state regulations on ISNs. The MMA opposes the RAPO assessment. It is doubtful that the state will be able to set an accurate "value" on the all-payer insurers' freedom from ISN regulations. The MMA urges the state to allow the market to work. Let patient choice, community need, and market forces determine the most effective delivery system. The MMA opposes a tilt toward either ISNs or RAPO.

Provide Adequate RAPO Fee Schedule

The MMA supports the MDH proposal to use the RBRVS (resource-based relative value scale) method of setting fees for services that are not delivered through an ISN and also supports having one payment area for the state. The conversion factor, which will be multiplied by the RVU (relative value unit) to set the fee schedule, will determine whether re-

RAPO continued on page 39

RAPO *continued from page 38*

imbursement in RAPO is adequate. The MMA believes that physicians must be allowed to comment and provide information when the state sets this conversion factor.

Base Payment on Provider Qualifications

The current MDH draft initially would reimburse physicians and other providers the same amount for the same service. Because of the depth and breadth of their training, physicians are able to provide more comprehensive and valuable care; therefore, the MMA recommends physicians be reimbursed at a higher rate.

Fund Research and Education

The MMA strongly supports the current practice of using state and federal general tax revenues to fund medical education and research.

Although the current MDH draft does not address this issue, discussions by the Minnesota Health Care Commission suggest that the state may propose changes in the funding of education and research. The MMA will closely monitor this situation.

Tort Reform

The MMA believes tort reform should be considered an important component of overall health system reform and has recommended a number of specific provisions that should be addressed.

Growth Limits

The MMA opposes basing growth limits on a three-year average of aggregate premium revenues unless the limits are also averaged. It is important to adhere to the original intent of the MinnesotaCare legislation, which allows adjustment of the global limit because of an aging or growing population. • • • • •

Good News

The growth limit for 1994 is 9.4 percent, not the estimated 9.2 percent.

Preview *continued from page 33*

programs, as well as a proposal to fund domestic abuse advocacy programs.

Preventing violence is a high priority for the MMA. The 1993 House of Delegates reaffirmed its commitment to achieve a violence-free society by the year 2010. Last year's family violence education and publicity campaign was highly successful. In October Gov. Arne Carlson presented the MMA an award commending the association for educating doctors about the signs of domestic and child abuse, funding public service announcements, holding training workshops for judges, and working with the Minnesota Coalition for Battered Women.

While the MMA has not taken a stand on the specific anti-violence bills that are expected this year, the proposals to prevent crime through education and to help victims of domestic abuse are in line with MMA policy. Proposals involving gun control may be more controversial. Resolutions aimed at limiting access to guns have provoked heated arguments in the MMA House of Delegates. Last year, however, the MMA supported a proposal that would have prohibited loaded firearms in areas accessible to children and required a trigger lock. The proposal did not pass but will be back this year in the Crime Bill.

Advertising

The 1993 MMA House of Delegates directed the MMA to "ensure the use of legitimate certifying boards and non-deceptive use of the term 'board-certified' in advertising." The MMA will work with the Minnesota Board of Medical Practice to develop appropriate legislative language.

BMP Diversion Program

Health licensing boards, including the Minnesota Board of Medical Practice (BMP), are seeking the introduction of a bill that would create a diversion program for providers who are chemically dependent or physically or mentally impaired. The program would be available to all the health licensing boards. Self-reporting to the program would be required, and those who did report would be required to comply with the directives of the program or be subject to disciplinary action. Such action would become public information. If the regulated person complied with the directives of the program, all data maintained by the program would be nonpublic. The MMA has a number of concerns about the BMP proposal. The bill would offer full immunity to those who report health care providers who are unable to practice with reasonable skill or safety. The MMA seeks the addition of language that would limit immunity to those who report in good faith. The MMA is also pressing for a rule-making process that would allow the MMA to continue to work out any differences over procedures with the BMP. The BMP opposes this rule making.

Data Collection and Dissemination

The MMA will attempt to ensure data privacy for patients and physicians as the data collection plans for MinnesotaCare go forward.

Balance Billing

A resolution adopted at the 1993 Annual Meeting directs the MMA to strongly support the passage of legislation that would allow physicians to bill up to the federal allowable amount for Medicare recipients with an annual income over 250 percent of the federal poverty level.

In 1993 the MMA supported two bills that would have repealed or limited the MinnesotaCare-mandated ban on balance billing for Medicare recipients. H.F. 1264 (Stanius)/S.F. 846 (Benson) would have allowed physicians to balance bill up to the federal allowable amount through means testing Medicare recipients. H.F. 360 (Gutknecht) would have repealed the phase-out of allowable balance billing. Neither bill received a hearing, but they may be revived this session.

Medical records

A proposal to amend Minnesota law governing the release of medical

Preview continued on page 40

Preview *continued from page 39*

records has been developed by the Medical Records Task Force and will be introduced this session. The MMA spearheaded this task force, which also included representatives of third-party payers and the Minnesota Hospital Association. Key legislators on the data committees were sought out for their input on changes to the law. The intent of the proposal is to clarify language in the law that is now so broad that physicians and clinics aren't sure how to handle the release of patient information.

Physician License Surcharge Repeal

The MMA House of Delegates directed the MMA to seek a total repeal of the physician license surcharge during the 1994 legislative session.

The MMA has already secured AMA support for efforts at the national level. At the 1993 Interim Meeting in December, the AMA adopted a Minnesota resolution calling on the AMA to seek repeal of the current Health Care Financing Administration policy that allows states to tax physicians in order to increase federal funding for Medicaid, and asking the AMA to support broad-based taxes to fund Medicaid.

Utilization Review and Workers' Compensation

The 1993 MMA House of Delegates directed the MMA to introduce legislation expanding the Utilization Review Act of 1992 to apply to all utilization review decisions made under workers' compensation, including all requirements for prior authorization in the treatment parameters for workers' compensation.

Chiropractic Scope of Practice

The Attorney General's office is currently reviewing a determination by the Board of Chiropractic that gynecological exams and Pap smears are within the scope of chiropractic practice. The 1993 MMA House of Delegates asked the MMA to request a review by the Attorney General, and, if necessary, to pursue "appropriate legislation to ensure the health and safety of women in the state of Minnesota."

Mandatory Malpractice Insurance

At the end of the 1993 session, Sen. Linda Berglin, DFL-Minneapolis, proposed an amendment that would have required all state physicians to carry malpractice insurance as a condition of licensure. The MMA cautioned against rushing forward without determining whether there was a problem, and warned that it could be a hardship on retired physicians who only keep their licenses so they can provide free care to the needy. The amendment died in conference committee.

Over the interim, the Consumer Protection Subcommittee of the House Commerce and Economic Development Committee held hearings on this issue, and a mandatory medical insurance bill is expected to be introduced this session.

The MMA does not yet have a position on this issue. The 1993 House of Delegates referred a resolution on this topic to the MMA Board. The board will take it up at the March 12 meeting.

Fee Review Companies

The MMA House of Delegates asked the MMA to pursue legislation that would review the financial arrangements between for-profit fee review companies and insurance or managed care companies.

Drunk Driving Penalties

The MMA House directed the MMA to seek legislation requiring that anyone who is convicted of driving while intoxicated or driving under the influence have his or her license suspended until after an evaluation for chemical dependency and, if indicated, treatment. A second conviction would result in the driver's license being suspended until the person has demonstrated sobriety for at least one year.

Classification of Learning Disabilities

The MMA House of Delegates asked the MMA to pursue legislation requiring mandatory coverage and reimbursement for the treatment of learning disabilities and attention deficit hyperactivity disorder at the same level as other neuro-developmental conditions.

Regulation of Traditional Midwives

The MMA House directed the MMA to oppose legislation that would transfer the responsibility of traditional midwives from the Board of Medical Practice to the Department of Health, and to oppose legislation and regulations that formally recognize home birth by traditional midwives as an acceptable and sanctioned option for child birth, unless midwives are required to be appropriately educated and licensed so as to ensure patient health and safety.

The BMP has decided to keep authority over midwives and is developing regulatory and educational policies for midwives. This is unlikely to be a legislative issue in 1994.

In addition to these expected proposals, a number of health care bills were stalled last year and may return, such as the ban on smoking in apartment and condominium common areas, and tort reform measures, including the comprehensive tort reform package initiated by the MMA. • • • • •

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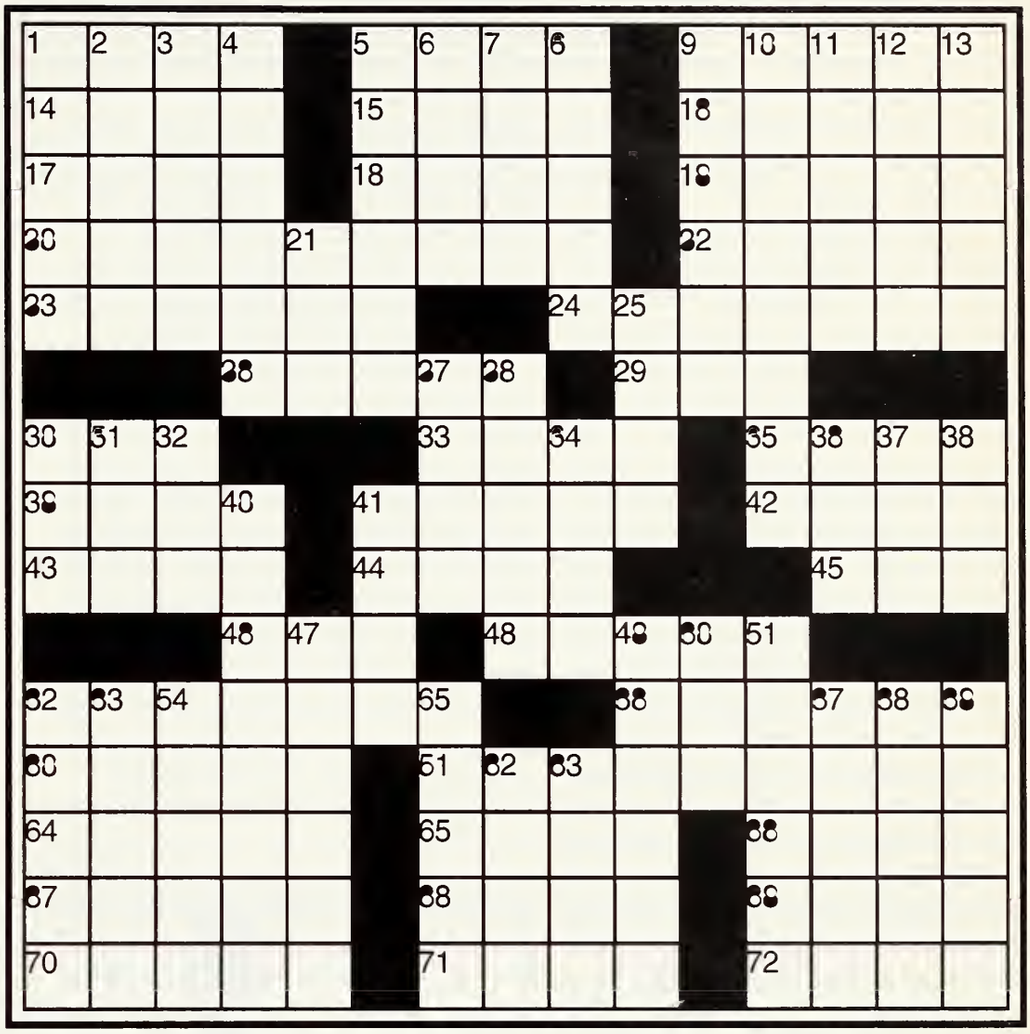
CROSS WORD PUZZLE

By Ernest Lampert, M.D.

General Practice



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ACROSS

1 Exanthem
5 Produce a remission
9 Use the inpatient bed
14 Put up
15 Biblical lions
16 Tropical vine
17 First white settler of S. Africa
18 Mature
19 Ger. philosopher et al
20 Kind of a twin
22 Deliver in second month
23 Ridicule
24 Layers of eye
26 Helpers (abbr.)
29 ETOH>0.1% (slang)
30 Dental prosthesis
33 Capital of GA
35 Altered form
39 Places where vessels enter
41 Pungent
42 Mediocre
43 Rustic poem
44 Invent
45 Sebaceous cyst
46 Position
48 A czar
52 Sires
56 Rubs out
60 On the qui vive
61 _____ischemic attack
64 Platform
65 S. Afr. money unit
66 Be partial
67 Spud
68 Der ____: Ger. politician
69 Aware of
70 Irish islands
71 A fruit
72 Eft

DOWN

1 Hydrophobic
2 Battery terminal
3 Castrated bovine
4 Abnormal bulge
5 Diseased teeth
6 Gouty acid
7 River bank
8 Asses (Ger.)
9 Not acid
10 Non-functioning islets
11 Landed estate
12 Prefix:within
13 Selectivity
21 49ers hope for
25 Iron-____ contract
27 Mexican falafel
28 Denude
30 Greek letter
31 Abet
32 Thickness
34 Provide inner cover
36 Inspire fear
37 Enzyme
38 Head tutor
40 May cause sneezing
41 Prefix:vinegar
47 Buries
49 Easily hurt
50 Fodder plant
51 Dried grape
52 e.g. linguini
53 Accessory in a church
54 A rope
55 Thong
57 Net
58 Provide for
59 Support
62 Breath sound
63 Pier

Solution on page 42

HALVORSON

(continued from page 7)

patient satisfaction is critically important. "We need to look at large teams of physicians reporting on groups of patients over the course of a year, otherwise data gathered will be statistically invalid and unusable," Halvorson argues.

For meaningful comparisons, he suggests tracking outcomes of a dozen or so care categories "that are most important to consumers and that account for most of the care we give—heart surgery, back care, and maternity care, for instance." This should satisfy the larger buyers, "who aren't interested only in big scorecards—they want to know that the basic process used to identify outcomes for all areas of care is scientifically sound and that care systems are using continuous quality improvement techniques in all areas of operation," Halvorson says.

Can capitation be translated into a compensation system for physicians that makes sense to all parties? HealthPartners has tried by either employing physicians or contracting with them in a group model plan like MedCenters. "Under such arrangements, performing more—or fewer—procedures for patients no longer affects a physician's pay. Their task is only to do what's best for their patients," says Halvorson. "What's more, we've found that by so doing, physicians become free to innovate in ways they never have before."

Opportunity for Innovation

Innovation is the name of the health care game in Minnesota. "We've already seen a paradigm shift here," says Halvorson. "Other parts of the country can't even spell what we are doing. Our challenge now is to move ahead without creating a highly bureaucratic system that would negate the advantages we're reaping from the market environment."

Halvorson is also optimistic about national health care reform, much of which has been modeled after approaches already in place here. "Clinton's plan includes universal coverage, which should be a given," he says. "Equally important, it would create the basic framework for a competitive model similar to Minnesota's in which consumers could choose between health plans based on quality, efficiency, and cost of care." His is not a blanket endorsement of the president's plan, however. "I worry about Clinton's proposal to create excessively large regional purchasing pools governed by powerful, arbitrary, and non-representative committees, and I'm concerned that not-for-profits won't have access to the capital they need to do business."

Nationally and locally, the health care industry and its leaders will continue to face dramatic change for some years to come, and Halvorson says he's up to the challenge. "It's a wonderful opportunity. I'm working with really good people in a company that can focus solely on its goals to provide the best health care at the best cost. I just can't imagine having more fun doing anything else." MM

Joseph Moriarity is a free-lance writer living in Marine on St. Croix.

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Solution to crossword puzzle from page 41

R	A	S	H		C	U	R	E		A	D	M	I	T
A	N	T	E		A	R	I	S		L	I	A	N	A
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C	A	P				A	T	L	A		E	C	A	D
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Strong Medicine, Bitter Pill

George C. Halvorson's "Strong Medicine" (Random House, 1993) offers cogent solutions to the health care crisis, but some of his arguments are hard to swallow.

Charles R. Meyer, M.D.

Cost and quality, quality and cost,
By which of these will we be bossed,
A penny here, a lost life there,
By our troubled priorities are we tossed.

Medicine today needs clear road signs. We need directions not only toward efficiency and effectiveness but also toward wisdom. Health care reform proposals are more numerous than deodorant brands, and providers are looking for an analysis that balances the clear need to control costs with the realities of patient care. "Strong Medicine" by George Halvorson attempts to wade through the morass and offer a route out. He partially succeeds.

Halvorson's credentials for addressing the subject are impressive. A former executive of Blue Cross-Blue Shield and Group Health, he is current president and chief executive officer of HealthPartners, the offspring of the Group Health-MedCenters merger. In "Strong Medicine," he looks at the major players in health care—doctors, hospitals, insurers and HMOs, and the government—and analyzes their contributions to the geometric rise in costs. He finds five structural flaws in our current system: risk-avoiding insurance, perverse fee-for-service incentives, outmoded provider structures, unaware purchasers, and "silver bullet" regulators (who react to isolated problems and "shoot them"). He proposes a quality-based system with integrated provider teams as a patch for these defects. Halvorson's analysis does ably identify most of the problems that previous fee-for-service critics have described, but his argument falters because of rhetorical excesses and inadequate defense of key proposals.

Exaggeration and anecdotal "proof" impair Halvorson's condemnation of our current medical care system. Doctors clearly do not fare well in these pages. According to Halvorson, their sins include pocket-lining techniques like "code creep," unbundling, and unnecessary callbacks. Physicians are not evil, he argues, but they do game the system. Do these practices ever occur? Sure. But I found myself asking, "Now who really does that?" when I read Halvorson's anecdotes of physicians thrown out of groups for not producing enough or "trolling for warts" to earn extra procedural dollars. Those who try to operate in an admittedly flawed system with honesty and caring can't help but feel unjustly accused in this book.

Halvorson's chapter on hospitals contains the extreme statement that "almost any" hospital's long-range strategy includes "creating an environment that enhances the ability of the private doctors who use that hospital to make large sums of money." I think most physicians in private practice would express surprise that hospital boards and administrators are so concerned about their financial well-being.

Halvorson's solution is a CQI-based system with integrated provider teams, simplified claims forms, large regional pools, and satellite clinics for rural care. Two core principles on which his future health care system rest are capitation and quality/outcomes measurement. He inadequately answers reasonable questions about these. When discussing the possible faults of a capitation system that encourages providers to do less, he tells the reader to "rest assured" that necessary care in such a system is not shirked. No studies are offered. No discussion of the physician's possible ethical dilemmas or breach of fiduciary responsibility in such a system is presented to assure us. He never explains how dumping risk in the provider's lap solves the problem of patient demand. In Halvorson's proposed system, quality assessment and outcomes management will guide purchasers' choices and check the potential detrimental effects of capitation on patient care. Although I share Halvorson's hope for outcomes-based management, I think he simplifies the complexities of developing accurate measurements that providers will see as fair and purchasers and patients will interpret sensibly.

"Strong Medicine" may be a bitter pill, but it presents a cogent argument for a pre-paid, vertically integrated system of care that mirrors the evolving HealthPartners system. It has an intriguing proposal for rural satellite clinics based on the Fargo

continued

and Marshfield clinics' experience. But Halvorson's case would be more compelling if he avoided the media-like use of anecdotes and hyperbole, answered the sincere concerns of capitation's critics, and confronted more directly the dilemma of patient demand in American society.

Our health care system does need change. We do need to find equitable means to measure what we do. We do need to strike a balance between cost and quality. Although flawed, "Strong Medicine" contributes to that resolution. MM

Charles Meyer is editor-in-chief of Minnesota Medicine.

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ISNs Are Super...but Super ISNs?

C. Randall Nelms Jr., M.D.

Despite state efforts to "level the playing field" by providing for both integrated service networks and an all-payer option, we instead seem to be in the process of creating a few "super" health maintenance organizations that will dominate the health care scene. If this happens, physicians will end up working for giant business entities, arrangements that could threaten our professional autonomy.

Commissioner of Health Mary Jo O'Brien stated in the August 1993 *Modern Healthcare* that "by prohibiting HMOs from using the same assets to satisfy both the HMO and ISN solvency requirements, and by also requiring HMOs to renegotiate provider contracts before using the contracts in an ISN, Minnesota hopes to level the playing field to enable locally based, provider-driven ISNs to form and compete with existing HMO, indemnity insurer, and Blue Cross/Blue Shield plans."

Yet, contrary to such assurances, we may be heading in the direction of super-large managed care plans, an approach that could leave only a few organizations with the financial clout to form networks. For example, according to one financial model for an ISN that would ultimately serve 300,000 east metro members in the Twin Cities, starting such a venture would require $63.8 million of capital. If the hospital network contributed half the capital, and if the network included 400 physicians, it would cost each physician $80,000 to join. It seems unlikely that this is what the MinnesotaCare law intended.

If Minnesota develops a health care system that relies only on large integrated networks, physician professionalism could be destroyed. Third-party managed care on such a large scale would replace physician judgment with nonphysician decision making. To avoid this loss of autonomy, we must ensure that the medical delivery systems we create include significant physician involvement in their health care delivery policies, similar to those of self-governing medical staffs in hospitals.

"Patient choice, community need, and market forces will determine the most effective delivery system."

Health care delivery under the Minnesota Department of Health's recently proposed all-payer option or through *provider-driven* ISNs would be preferable to the creation of three or four health care mega-conglomerates. Many patients want their choice of physicians, and they are willing, if necessary, to pay a premium to preserve choice. Under the all-payer option, the patient would have unrestricted choice of providers. Fees would be regulated, but treatment decisions would be left to the physician, who would allocate the resources. In addition to fee controls, an annual volume performance standard would be necessary to effectively control costs. Copayments and deductibles would be used to control unnecessary utilization by patients, and physicians could be in charge of utilization review through their professional organization. Both individuals and provider associations could review and act on analyses of all-payer quality and utilization performance. If providers were allowed to form networks in the all-payer option, managed care techniques could easily be carried out without third-party intrusion.

Locally based, provider-driven ISNs would also offer greater patient choice than super HMO-like entities because many providers in the community would participate. Physicians in these plans would have significant involvement in the ISNs' health care delivery policies and procedures, including medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters.

Citizens in this state must insist that health system reform provide for maximum flexibility in network design and development to allow for community participation in medical care delivery as well as in disease prevention and health promotion. Minnesota should not be too hasty or too rigid in its efforts to create new health care delivery systems. It would be a mistake for the state to rely on preconceived notions about what type of systems should be created for all its communities. ISNs are innovative, but they're still experimental. Patient choice, community need, and market forces will determine the most effective delivery system. MM

Minnesota Medicine is the official journal of the Minnesota Medical Association, and its purpose is to provide Minnesota physicians with timely information regarding all aspects of medicine so they can more capably serve their patients and more readily achieve their professional goals. Therefore, the editors are pleased to consider for publication clinical and health papers (clinical studies, reviews, case reports) and essays, letters, poems, and opinion pieces related to medical practice in Minnesota.

Manuscripts

Submit clinical articles, essays, letters, book reviews, and other manuscripts at any time to: Meredith McNab, Managing Editor, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. Manuscripts are reviewed by the editors and peer reviewed by the Advisory Committee, the Review Board, and other experts in particular specialties.

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A cover letter should identify the author with whom we correspond (include address and phone number). Double-space all text on one side of paper only, including references, legends, etc., and number pages consecutively.

Receipt of manuscripts is acknowledged within 10 days, and authors are usually notified whether their manuscript is accepted within one to three months, but longer delays are sometimes unavoidable.

Title and Authors' Names

The first page of the manuscript should include: 1) a title—make it short, specific, and direct, 2) the full names of all authors, with their academic degrees, 3) authors' positions in hospitals or other institutions—include current position and the position held when the work reported in your manuscript was done, as well as academic appointments and other information pertinent to the paper's topic.

Abstract

The second page of the manuscript should include an abstract no longer than 150 words that highlights for the reader the essence of the authors' work. It should focus on facts rather than descriptions and should emphasize the importance and uniqueness of the findings and briefly list the approach used for gathering data and the conclusions drawn.

Author Responsibility

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Style

Use *JAMA* style or consult the AMA's *Manual for Authors & Editors*. Use generic drug names, unless citing a brand name relevant to your findings; brand names in parentheses may follow generic names if desired. Do not use abbreviations in the title, and limit their use in the text. Avoid medical jargon.

Tables

Tables must have a title and be on separate pages. If they occupy more than one page, type "*title* (cont.)." If the data in the tables have been previously published, appropriate reference should be given in the text, and permission should be obtained from the original publisher before submission to *Minnesota Medicine*.

Illustrations

Submit two copies of illustrations, keeping one for your files. Figures should be professionally drawn or photographed, if possible. We prefer glossy, clear black-and-white photographs, but color is acceptable if the contrast is good. Do not send original artwork.

Each figure should have a label pasted on the back indicating the figure number, author names, and the top of the figure. Legends should be included in the text of the manuscript with numbers corresponding to the figures. Do not mount figures on cardboard, write on the back of the figures, or attach paper clips to them. If a patient in a photo is identifiable, a written release form from the subject must accompany the photo.

References

All references must be cited in the text and should be arranged in the order in which they are cited in the text—*not* alphabetically. Journals should be abbreviated as in *Index Medicus*.

Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. Mayo Clinic Proc 1986;61:859-64.
2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. Dis Colon & Rectum, to be published.
3. Chaterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.
4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. Pediatric Surgery, 4th ed. Chicago: Year Book Medical, 1986: vol 1, 522-33.

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People and Places Making Medical News

People

Sister Kenny Institute Medical Director

Jennine Speier, M.D., has been appointed medical director at the Sister Kenny Institute in Minneapolis. Speier, clinical research director and staff physician at the Sister Kenny Institute since 1984, is board certified in physical medicine and rehabilitation. She served as the lead physician liaison with the Sister Kenny Institute Innovation Team and was instrumental in shaping the planned redesign of patient care delivery within the institute.

HCMC Ambulatory Services Administrator

Arif Altaf, former Family Medical Center (FMC) administrator, was named associate administrator of Ambulatory Services, a newly established Hennepin County Medical Center position. In this role, he will oversee HCMC's outpatient clinics, FMC, the Minnesota Regional Sleep Disorders Center, Hennepin Care-North, and the Diabetes Program.

New Medica Health Center Executives

Medica named **Susan Rawlings** executive director and **Colleen Swanson** marketing and sales manager for its new Center for Healthy Aging. Before joining Medica, Rawlings was director of the Senior Choice product at Partners/Aetna Health Plan in Tucson, Arizona.

For the past three years, Swanson has served as group sales manager for Mutual Service Life Insurance.

HealthSpan GPO Executives

Thomas G. Schwinghamer, M.D., has been named physician executive and **Steven R. Youso** has been named administrative executive for the east region of HealthSpan's Group Practice Organization. Prior to this appointment, Schwinghamer had been the president and chief executive officer of HealthSpan's River Valley Clinic. As physician executive, Schwinghamer will oversee the maintenance of clinics in the east region, as well as deal with all aspects of purchasing clinics. Youso, who formerly served as administrator of the River Valley Clinic in Hastings, will handle the administrative details of managing the east region clinics after they become part of the HealthSpan organization.

Places

'U' Raises Funds for Cancer Center

University of Minnesota officials report they have collected $30.5 million for the creation and staffing of a new cancer center on the Minneapolis campus, marking the end of a fund-raising drive that began in 1991. Construction of the center, which will be located next to the University Hospital at East River Road, is expected to be completed by January 1996. The center will house future and existing cancer research at the university. The new center is expected to enhance the university's cancer research reputation and to generate additional federal grant money and patient revenue.

HealthEast Opens Continence Center at Midway

HealthEast recently opened a new facility for the treatment of bladder or bowel control loss, called the HealthEast Continence Center. The new center, based in the endoscopy lab located in the HealthEast Midway Hospital in St. Paul, provides diagnoses, treatments, and counseling for referred patients of all ages. The facility also serves as a regional referral center for pelvic pain studies and experimental treatments for voiding disorders.

Minneapolis Children's Constructing Ambulatory Center

The Minneapolis Children's Medical Center's new outpatient center, Minneapolis Children's-West, will be the first freestanding, hospital-affiliated pediatric ambulatory center in the region. Construction of the center, located at the intersection of I-494 and Crosstown Highway 62 in Minnetonka, is expected to be completed by August.

The $6.5 million, 26,000-square-foot center will ultimately offer a range of ambulatory services, including same-day surgery, diagnostic testing, radiology, and rehabilitation services.

Community Clinic Opens in Minneapolis

Green Central Community Clinic, the first community clinic in Minneapolis to be based in a school, opened in January at Central Neighborhood Early Learning Center at the Richard Green Central Park Elementary School on East 35th Street. The new clinic aims to provide affordable prevention and primary care to families and children in the Powderhorn Community. In addition, the clinic will offer several on-site social services and educational programs through other agencies.

Socioeconomics

'U' Health System and Fairview to Join Blue Cross ISN

The University of Minnesota Health System (UMHS), Fairview Health System, and Fairview Physician Associates (FPA) are joining Blue Cross and Blue Shield of Minnesota and Aspen Medical Group to form an integrated service network serving the greater Twin Cities metropolitan area. Blue Cross and Aspen forged an alliance last year as a first step in developing an ISN. The 329 FPA physician members and 120 Aspen physicians will be the primary and specialty care physician network for the ISN. The University of Minnesota Hospital and Clinic and university physicians will provide specialty referral services for the ISN that cannot be provided within the Aspen and Fairview networks. The groups expect to further expand the ISN in coming months.

The Blue Cross network is not a merger or consolidation, and none of the organizations will participate in the ISN exclusively. Blue Cross participates with all Minnesota nonfederal hospitals and 97 percent of all physicians. Fairview, FPA, UMHS, and Aspen each participate in numerous other plans and have other patient care affiliations and teaching relationships. All of these relationships are expected to continue. The organizations can also pursue other alliances.

CMC Joins HealthSpan ISN

Comprehensive Medical Care (CMC), a 54-member physician group based in Coon Rapids, announced a closer affiliation with HealthSpan in preparation for an integrated service network. CMC has had a management contract with HealthSpan since 1987, but this new affiliation will integrate CMC into HealthSpan's new group practice organization, a formal structure that consolidates the business operations of HealthSpan physician practices and unites them in a self-governing network.

MinnesotaCare Faces Deficit

MinnesotaCare is headed for a shortfall unless the 1994 Legislature can find a solution. State health care planners said that, on its current path, the program will come up $246 million short by 1997. As a result, up to 150,000 Minnesotans who were promised subsidized health insurance next July could be denied coverage.

The MinnesotaCare program includes a provision that it cannot spend more money than it takes in. The group that becomes eligible for coverage in July includes single adults and families with or without children who earn less than 275 percent of the federal poverty level, are ineligible for Medical Assistance, have had no access to employer-subsidized health care coverage for the past 18 months, have been uninsured for four months, and are permanent Minnesota residents. This could include up to 150,000 of the estimated 300,000 uninsured in Minnesota, officials say. "We do not have enough money to enroll that group," said George Hoffman, director of reports and forecasts for the state's Human Services Department.

Michael Scandrett, executive director of the Minnesota Health Care Commission, said that despite the July 1 deadline, there is no urgency to solve the financing problems permanently this session because the deficit is a few years away and national health care changes may eliminate the problem. Nonetheless, the Human Services Department and the Minnesota Health Care Commission are trying to develop possible solutions before the legislative session begins this month.

MDH Report: Minnesota's HMOs Financially Sound

The state's 12 health maintenance organizations are financially sound and have had relatively stable membership the past six months, according to the Minnesota Department of Health's latest HMO status report. HMO membership peaked in 1987 at 1.21 million, then dropped to 1.11 million in 1988. Since then, HMO membership has steadily increased until it hit 1.2 million in 1992.

Minnesota HMOs had gross revenues from premiums and investment earnings during 1992 of $1.9 billion, and they spent $1.6 billion on health care for their members and $216 million on administrative expenses while earning $66 million in profit.

The most profitable HMO was Medica Choice, which cleared $31 million in profits. Blue Plus followed with $9.2 million; Metropolitan Health Plan with $8.2 million; Medica Primary, $7.6 million; MedCenters, $2.4 million; UCare, $2.3 million; Group Health, $1.7 million; HealthPartners, $1.4 million; Central Minnesota Group Health, $1.1 million; Mayo Health Plan, $588,000; First Plan HMO, $150,000; and Northwestern National Life Health Network, $12,000. All HMOs have at least the mandated 8.3 percent of annual expenses in reserve, according to the report.

Care Varies Among HMOs

Patients enrolled in employer-based plans get more preventive care than people in HMO Medicaid or HMO Medicare plans, according to the Minnesota Department Health's report on HMOs.

For example, in 1992, HMOs performed Pap smears on 46 percent of "at risk" women in their employer-based plans; 32 percent of their HMO Medicaid members, and 24 percent of HMO Medicare members. The HMOs performed mammograms on 50 percent of women considered at-risk for

cancer (50 and older) who are in employer-based plans, 38 percent in HMO Medicare; and 12 percent in HMO Medicaid plans.

The Health Department's report showed a growing number of Medical Assistance recipients who receive health care through HMO managed care systems. The number nearly doubled in 1992 to 92,000—about 8 percent of the total HMO enrollment, or 16 percent of the state's Medical Assistance population.

Office visits averaged 3.3 per member per year for General Assistance recipients, 3.5 visits for members of traditional HMO plans, 4.2 for Medicaid recipients, and 5.5 for members who also receive Medicare. Traditional HMO plans provided 257 days of hospital acute care a year per 1,000 members. The number nearly doubled for Medicaid patients to 537 days per year and increased to 1,022 for General Assistance patients and 1,322 for Medicare patients. The report showed the largest range of use for emergency room care. For each 1,000 members, traditional plans provided 97 visits that did not result in a hospital stay, Medicare provided 115 visits, Medicaid 565 visits, and General Assistance 585 visits.

Minnesota State Health Plan to Cover Marrow Transplants

The Minnesota State Health Plan will cover the cost of bone marrow transplants for women enrolled in a National Cancer Institute study, a state official said in January. The plan covers 25,000 state, university, and college officials and employees. The master contract for the plan will be amended to cover women in the study, but not those who don't qualify for the program, which is enrolling 340 women nationwide.

The change is being made after a University of Minnesota Hospital nurse with breast cancer filed a lawsuit when she discovered the plan had dropped coverage of the treatment for 1994.

Commission Recommends Means to Cut Nursing Home Costs

The Minnesota Long-Term Care Commission has recommended a strategy for trimming increased spending on care for seniors over the next five years. The proposals include allowing nursing homes to reduce food servings that typically are too large to finish, streamlining regulations, and providing incentives and services to help older people remain in their homes.

The commission was estab-

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lished by the 1993 Legislature and appointed by the governor to find ways to cut the growth in state spending for long-term care by 10 percent a year for the next five years—a total of $62.2 million.

Among the commission's other suggestions are a nursing home demonstration project that would allow wide experimentation in delivery of services under relaxed rules; consumer incentives, including family support grants and tax credits to help people keep elderly relatives at home; an allowance for elderly patients to pay for home care services; and support for community programs for the elderly.

Iron Range Gets Help to Attract Doctors

The Iron Range Resources and Rehabilitation Board voted to chip in $250,000 for a plan to attract more physicians to the Iron Range. The program will offer physicians bonuses of $10,000 a year for three years to practice on the Range. After three years, the health care facility that hires the doctor will return half the bonus money to the recruitment fund.

Rates, Trends, Data

Six Percent of Newborns Test Positive for Drugs

Almost 6 percent of newborns at four Twin Cities hospitals tested positive for marijuana, cocaine, or opiates in a new study released by the Minnesota Department of Human Services. The percentage in Minnesota appears to be declining, and drug exposure is less prevalent than in some other parts of the country. For example, only 2 percent of Twin Cities newborns tested positive for cocaine, compared with 31 percent in a 1989 study of infants in inner-city Detroit. Studies in inner-city New York and inner-city and suburban Philadelphia found that 11.5 percent to 15.3 percent of newborns had been exposed to cocaine. The research also showed lower rates of drug exposure than were found in a 1989 study of a similar Twin Cities population.

The study of newborns involved 1,333 infants at unnamed hospitals in Minneapolis, St. Paul, and the suburbs. It used a stool analysis technique that detects any drug use during the last three to four months of pregnancy.

The department's biannual report on drug abuse in the Twin Cities also noted an increase in cocaine-related deaths, hospital emergencies, and treatment admissions for the third straight year, although 1989 remains the peak year.

Law & Policy

Physicians Can Itemize New 2 Percent Provider Tax

U.S. District Court Judge David Doty ruled in December that the state Legislature's attempt to prohibit physicians and other health care providers from itemizing the new 2 percent provider tax on patients' bills violates their constitutional right to free speech. MinnesotaCare legislation allowed providers to pass the tax on to patients, but it prohibited them from itemizing it on patients' bills. A group of health care professionals—three physicians, a dentist, and a pharmacist—filed a lawsuit alleging that the provision "is simply a cynical attempt by the Legislature to avoid responsibility for creating a new tax," Doty wrote. The tax took effect January 1.

AIDS Lawsuit Settled

In a case that received national attention, a Minnesota union and its health plan agreed in December to pay $100,000 to settle an AIDS discrimination lawsuit. The health insurance plan for Local 110 of the International Brotherhood of Electrical Workers had limited the amount it would pay in lifetime AIDS benefits to $50,000, while it insured other catastrophic conditions up to $500,000. The estate of Mark Kadinger and the University of Minnesota Hospital and Clinic filed suit in U.S. District Court in Minneapolis in March 1993. Kadinger, who worked for Collins Electric in St. Paul, reached the $50,000 limit six months before he died.

The union has agreed to pay $100,000 to Kadinger's estate and make a $2,500 donation to the Minnesota AIDS Project. In addition, the insurer must remove the AIDS cap and for the next three years notify the Equal Employment Opportunity Commission of any changes in coverage relating to disabilities.

The Americans With Disabilities Act, which went into effect in July 1992, prohibits discrimination against people with disabilities. The new law raised questions about the legality of self-insured plans limiting AIDS coverage below levels for other catastrophic illnesses. Because federal law exempts self-insured plans from state regulations, they have been able to institute lower benefits for AIDS.

Although the case was settled out of court, it should serve as a model for similar cases in the nation because the settlement must be signed by a judge, meaning it carries the implications of a court order, said Keith Halleland, an attorney who represented the university and Kadinger's estate.

Medical Research

'U' Scientist Develops Promising Cancer Vaccine

University of Minnesota researcher Emmanuel Katsanis, M.D., said he has developed a promising vaccine for the childhood cancer neuroblas-

toma and is about two years from beginning human trials. He told the Minneapolis-based *Star Tribune* that the vaccine has been "significantly successful" in mice that have been seeded with neuroblastoma tumors, which are almost identical to such tumors in people.

The vaccine consists of neuroblastoma tumor cells spliced with genes that produce interleukin-2. The goal is to stimulate the immune system to attack and destroy the tumor.

In his experiments, Katsanis starts with 40 mice with neuroblastoma tumors. He injects the vaccine into some, injects irradiated tumor cells into others, and does nothing with the rest. After 30 days, all the mice given no treatment and most of those given irradiated tumor cells are dead. Most given the vaccine are still alive and the tumors have disappeared. Katsanis has repeated the experiment four times, and the results have been similar, he said.

The results of the study have been accepted for publication in the *Journal of Immunotherapy*.

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Session I	Thomas Gutheil, M.D.	Malpractice Prevention in Mental Health
Session II	Peter Brill, M.D., Alan McLean, M.D. & Len Sperry, M.D., Ph.D.	Effective Organizational Consultation: Developing the Necessary Skills
Session III	James Gustafson, M.D.	The Essentials of Brief Psychotherapy for Families, Couples and Individuals

August 1-5

Session IV	Glen O. Gabbard, M.D.	Psychotherapeutic Strategies with Borderline Patients
Session V	Diane Adile Kirschner, Ph.D., & Sam Kirschner, Ph.D.	Treating Survivors of Incest and Abuse
Session VI	Mariellen Fischer, Ph.D., Thomas A. Hammeke, Ph.D., Robert F. Newby, Ph.D., Steve M. Rao, Ph.D., & Sara J. Swanson, Ph.D.	Advanced Topics in Neuropsychological Assessment and Treatment

August 8-12

Session VII	John H. Greist, M.D., James W. Jefferson, M.D. & David J. Katzelnick, M.D.	Psychopharmacology Consultations
Session VIII	Jeffrey A. Kelly, Ph.D., David G. Ostrow, M.D., Ph.D., & Kathleen J. Sikkema, Ph.D.	AIDS/HIV Prevention, Therapy, and Mental Health Consultation Issues

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Hepatitis B Vaccine Frequently Ineffective

The hepatitis B vaccine frequently fails to trigger immune responses in some groups of people, particularly older, heavier men who smoke, according to a study by Minnesota Health Department researchers published in the December 22 *Journal of the American Medical Association*. Although the researchers aren't certain, they believe that people who fail to develop antibodies are not protected against the hepatitis B virus.

State epidemiologist Michael Osterholm, who wrote the report on the study, and colleagues at the health department, closely examined the records of 595 health care workers who were vaccinated against the virus in 10 hospitals across the state. The rate of antibody development dropped as age and body size increased. The rate also dropped for males and for all smokers. Those at highest risk for not producing antibodies were older men who smoked. Those most likely to develop antibodies were young women who don't smoke and have low body mass.

Mayo Study: Heart Attack Treatments Equally Cost-Effective

A Mayo Clinic study that compared the costs of care for 51 patients who had their heart attacks treated with tissue plasminogen activator (t-PA) and 48 patients who were treated with immediate angioplasty found that the average investment to save 1 percent of the left ventricle was $1,659 for the t-PA group and $1,654 for the angioplasty group. The study measured all costs for a year after treatment began. This included the direct costs of hospital and professional charges and indirect costs, which included days of hospitalization, time away from work, change in work status, change in personal income, level of physical activity, and quality of life.

The study also reported a trend toward shorter hospital stays and fewer in-hospital procedures after the initial treatment for patients who received angioplasties.

Guy Reeder, M.D., a Mayo cardiologist who directed the study, said that the cost results, when paired with a companion study that showed comparable results for angioplasty and t-PA in terms of heart muscle saved, mean that "patients can feel quite comfortable with either treatment for a heart attack—both are just as good, as long as the angioplasty is done promptly." MM

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FEBRUARY 1994

Feb. 5 **Office Urology for Primary Care Physicians** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Feb. 5-9 **Selected Topics in Internal Medicine** Mayo Foundation; Silverado Resort, Napa, CA. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME, Siebens 5, 200 First Street SW, Rochester, MN 55905; 507/284-2509 or 800/323-2688.

Feb. 10-14 **Mayo Clinic State-of-the-Art Symposium: Arrhythmia Management** Mayo Foundation; Napa Valley, CA. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME, Siebens 5, 200 First Street SW, Rochester, MN 55905; 507/284-2509 or 800/323-2688.

Feb. 11 **Minnesota Urological Society Pyelogram Conference** Minnesota Urological Society; Registry Hotel, Bloomington, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875 or 800/999-1875.

Feb. 18 **Infectious Disease in Immunocompromised Patients** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Feb. 18-24 **A Winter Olympics Study Trip: Advances in Diagnostic Radiology** University of Minnesota, Department of Radiology; Oppdal, Norway. CONTACT: Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Feb. 21-22 **Advanced Trauma Life Support (ATLS)** HealthSpan; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7910.

Feb. 21-25 **Neurology in Clinical Practice** Mayo Foundation; Keystone Resort, Keystone, CO. CONTACT: Rita Kunz or Jan Fleck, Section of CME, Siebens 5, Mayo Foundation, 200 First Street SW, Rochester, MN 55905; 507/284-2509 or 800/323-2688.

Feb. 23-24 **Geriatric Drug Therapy Symposium** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Feb. 24-25 **Advanced Pediatric Life Support** Hennepin County Medical Center; Hennepin County Medical Center, Minneapolis, MN. CONTACT: Rachel Knudson, R.N., EMS Training, Hennepin County Medical Center, 701 Park Avenue South, Minneapolis, MN 55415; 612/347-3638.

Feb. 24-26 **Epilepsy Update—Basic Mechanisms of Anticonvulsant Treatment** Minnesota Epilepsy Group/Barrow Neurological Institute; Buttes Conference Resort, Tempe, AZ. CONTACT: Annette Carlson, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7910.

Feb. 25 **Annual Burn Care Today Conference** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Feb. 25 **Prevention and Management of Atherosclerotic Diseases** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

MARCH 1994

Mar. 3-4 **Gentle Journey: Annual Conference on Palliative Care** HealthEast Hospice and Carondelet HealthCare Foundation; St. Paul Radisson, St. Paul, MN. CONTACT: HealthEast Hospice, 69 West Exchange Street, St. Paul, MN 55102; 612/232-3051.

Mar. 5 **The Cure of Breast Cancer** HealthSpan Health Systems Corp, Hotel Sofitel; Bloomington, MN. CONTACT: Don Young, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

Mar. 5 **Schizophrenia Update** Behavioral Health Services of Abbott Northwestern Hospital; Minneapolis Hilton & Towers, Minneapolis, MN. CONTACT: Don Young, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

Mar. 6-12 **Third Annual Minnesota Costa Rica Medical Week: Diagnostic and Therapeutic Frontiers in Medicine** University of Minnesota and Autonomous School of Medical Sciences of Central America; Hotel Bougainvillea, San Jose, Costa Rica. CONTACT: Hugh D. Westgate, M.D., 800 East 28th Street, Children's Heart Fund, Minneapolis, MN 55407; 612/863-5460.

Mar. 7-11 **Medical Update 1994** University of Minnesota Department of Surgery, Continuing Medical Education, Medical School, Continuing Education and Extension; Fort Lauderdale, FL. CONTACT: Medical Update 1994, Office

of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Mar. 10 **Medica Foundation/University of Minnesota Lecture Series on "The Task of Medicine: A Rich Past and an Open Future." Beethoven and Medical Practice in 19th Century Vienna** University of Minnesota Program in Human Rights and Medicine and Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Mary Krumholz, 1121 Marion Street, St. Paul, MN 55117; 612/487-9715.

Mar. 10-11 **Annual Family Medicine Today Conference** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Mar. 11-12 **Advanced Life Support in Obstetrics (ALSO)** HealthSpan; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7910.

Mar. 17-18 **Allergy and Clinical Immunology** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Mar. 17-18 **Critical Care: A Focus on Practical Management** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Mar. 18 **Minnesota Urological Society Pyelogram Conference** Minnesota Urological Society; Registry Hotel, Bloomington, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875.

Mar. 19-25 **Radiology: Brain to Pelvis 1994** University of Minnesota; Pines Lodge, Beaver Creek, CO. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Mar. 24 **Medica Foundation/University of Minnesota Lecture Series on "The Task of Medicine: A Rich Past and an Open Future." Ethical Aspects of the Human Genome Project and Genetic Science** University of Minnesota Program in Human Rights and Medicine and Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Mary Krumholz, 1121 Marion Street, St. Paul, MN 55117; 612/487-9715.

Mar. 25 **Fifteenth Annual Occupational Medicine Update** St. Paul-Ramsey Medical Center; Minneapolis Metrodome Hilton, Minneapolis, MN. CONTACT: Bonnie Young, Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Mar. 25-26 **Eating Disorders** University of Minnesota; Sheraton Inn Midway, St. Paul, MN. CONTACT: Rebecca

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Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Mar. 25-27 **Third Annual Conference on Advances in Clinical Anesthesiology** Mayo Foundation; Amelia Island Plantation, Amelia, FL. CONTACT: Rita Kunz, Mayo Foundation, Section of CME, Siebens 5, 200 First Street SW, Rochester, MN 55905; 507/284-2509 or 800/323-2688.

Mar. 31 **Progress in Health Care Reform: Minnesota and the Nation** University of Minnesota; Sheraton Inn Midway, St. Paul, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

APRIL 1994

Apr. 7-8 **Annual Ob/Gyn Update** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 7-9 **Nineteenth Annual Spring Continuing Education Seminar** Minnesota Academy of Physician Assistants; Holiday Inn-Airport, Bloomington, MN. CONTACT: Sonja L. Gedko, PA-C, 8575 Magnolia Trail, 203, Eden Prairie, MN 55344; 612/944-9388.

Apr. 8 **ENT Update** St. Paul-Ramsey Medical Center; St. Joseph's Hospital, St. Paul, MN. CONTACT: Bonnie Young, Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

MMA-Accredited CME Sponsors

❧ The Minnesota Medical Association is the accrediting agency for Minnesota institutions that regularly sponsor CME activities for local physicians. ❧ Accreditation gives CME sponsors responsibility for conducting high-quality CME programs and for designating the amount and category of credit for CME activities. ❧ CME programs must comply with the MMA's "Essentials for the Accreditation of Sponsors of Continuing Medical Education" and "Standards for Commercial Support of CME." ❧

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- ❧ Fairview Ridges Hospital, Burnsville
- ❧ Lakeview Memorial Hospital, Stillwater
- ❧ Mesabi Regional Medical Center, Hibbing
- ❧ Minneapolis Children's Medical Center, Minneapolis
- ❧ Rice Memorial Hospital, Willmar

For more information on the MMA accreditation program, please call Jane Phillip at the MMA, 612/378-1875 or 800/999-1875.

Apr. 14-16 **Trauma of Upper Extremity Fractures and Dislocations of Wrist, Elbow, and Shoulder** Mayo Foundation; Scottsdale, AZ. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME, Siebens 5, 200 First Street SW, Rochester, MN 55905; 507/284-2509 or 800/323-2688.

Apr. 15 **The 10th Annual Duluth Heart Conference** Duluth Clinic; Duluth Entertainment & Convention Center, Duluth, MN. CONTACT: Rockie Odberg, 400 East Third Street, Duluth, MN 55805; 218/725-3838.

Apr. 15 **Ventricular Arrhythmias** University of Minnesota; Earle Brown Heritage Center, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Apr. 15-16 **Seventeenth Annual Update in Clinical Cardiology** Minneapolis Heart Institute Foundation; Radisson Plaza Hotel, Minneapolis, MN. CONTACT: Don Young, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

Apr. 16 **The Treatment of Prostate Cancer** Minnesota Urological Society; Minneapolis Hilton and Towers, Minneapolis, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875.

Apr. 21 **Medica Foundation/University of Minnesota Lecture Series on "The Task of Medicine: A Rich Past and an Open Future"** Program in Human Rights and Medicine, University of Minnesota, Continuing Medical Education; Grand Ballroom, Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Mary Krumholz, 1121 Marion Street, St. Paul, MN 55117; 612/487-9715.

Apr. 21-22 **Bone Marrow Processing Laboratory** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Apr. 22-23 **Minnesota Orthopaedic Society 10th Annual Meeting** Minnesota Orthopaedic Society; Phillips Hall, Siebens Education Building, Rochester, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875.

Apr. 25-26 **Advanced Trauma Life Support (ATLS)** HealthSpan; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7910.

Apr. 25-29 **Family Practice Review and Update 1994** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Apr. 29 **Agricultural Health & Safety** St. Paul-Ramsey Medical Center; Location to be announed. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 29-30 **Pelviscopic Surgery Including Laparoscopic Hysterectomy** Abbott Northwestern Laser Center; Abbott Northwestern Hospital, Minneapolis, MN. CONTACT: Don Young, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

Apr. 30 **Minnesota Society of Pathologists Spring Seminar** Minnesota Society of Pathologists; Hennepin County Medical Center, Minneapolis, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875 or 800/999-1875.

MAY 1994

May 1-4 **Second International Congress of the Cell Transplant Society** University of Minnesota; Hyatt Regency Hotel, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 10 **Symposium on Gynecologic Oncology** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 11-13 **Current Concepts in Radiation Therapy** University of Minnesota; Mayo Memorial Auditorium, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 12 **Central Minnesota Medical Conference** St. Cloud Clinic of Internal Medicine, Ltd.; St. Cloud Holiday Inn, St. Cloud, MN. CONTACT: Kellee Zwilling, 1200 Sixth Avenue North, St. Cloud, MN 56303; 612/240-2155.

May 12-13 **Primary Biliary Cirrhosis: A Look to the Future** Mayo Foundation; Kahler Plaza Hotel, Rochester, MN. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME, Siebens 5, 200 First Street SW, Rochester, MN 55905; 507/284-2509 or 800/323-2688.

May 19-21 **Disability Evaluation & Management** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

May 20 **1994 Emergency Medicine Conference** Duluth Clinic; Duluth Entertainment & Convention Center, Duluth, MN. CONTACT: Rockie Odberg, 400 East Third Street, Duluth, MN 55805; 218/725-3838.

May 20-21 **Current Retina Practices for the Comprehensive Ophthalmologist** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

JUNE 1994

June 2-4 **Workshops in Clinical Hypnosis: Introductory and Advanced** University of Minnesota; Sheraton Inn Midway, St. Paul, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 15-17 **Topics and Advances in Pediatrics** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 15-18 **Fifty-sixth Annual Course: Hepatic Biliary and Pancreatic Surgery** University of Minnesota; Willey Hall at University of Minnesota and Hyatt Regency Hotel, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 17-18 **Mayo Ophthalmic Reviews** Mayo Clinic, Department of Ophthalmology; Mayo Medical Center, Rochester, MN. CONTACT: Darcie Skoda, Department of Ophthalmology, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; 507/284-1709.

JULY 1994

July 14-15 **Advanced Pediatric Life Support** Hennepin County Medical Center; Hennepin County Medical Center, Minneapolis, MN. CONTACT: Rachel Knudson, R.N., EMS Training, Hennepin County Medical Center, 701 Park Avenue South, Minneapolis, MN 55415; 612/347-3638.

AUGUST 1994

Aug. 22-Sept. 2 **Twelfth Annual Occupational Health and Safety Institute** St. Paul-Ramsey Medical Center; University of Minnesota, Mayo Building, Minneapolis, MN. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

SEPTEMBER 1994

Sept. 22-23 **Domestic Violence** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

OCTOBER 1994

Oct. 6-7 **Advanced Pediatric Life Support** Hennepin County Medical Center; Hennepin County Medical Center, Minneapolis, MN. CONTACT: Rachel Knudson, R.N., EMS Training, Hennepin County Medical Center, 701 Park Avenue South, Minneapolis, MN 55415; 612/347-3638.

Oct. 27-28 **Trauma Management for Primary Care Providers** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

NOVEMBER 1994

Nov. 10-12 **Strategies in Primary Care Medicine** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Physician Opportunities and Miscellaneous Listings

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Family Practitioner, Internal Medicine, Ob/Gyn, Pediatrician to join a progressive 13-physician group practice. Rural college town 30 miles from St. Paul, Minnesota. New clinic and new hospital. Contact Robert B. Johnson, M.D., River Falls, WI 54022; 715/425-6701. (*1/93-R)

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Family Physicians, P.A., 612/835-3609, or send inquiries to 7801 East Bush Lake Road, Suite 400, Bloomington, MN 55439. (*3/93-R)

Mankato Clinic, Ltd. is seeking additional BC/BE physicians in the following specialties: orthopedics, radiology, invasive cardiology, oncology/hematology, family practice, and general internal medicine. The Mankato Clinic is a 59-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. M. P. Wheeler, President, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (10/93-R)

BC/BE Internal Medicine and Ob/Gyn Physician: Excellent opportunity to join a well-established, progressive, 26-physician multispecialty group located in an economically sound community of 22,000 (drawing area of 45,000), 65 miles south of the Twin Cities. Full membership after one year. Competitive salary and fringe benefits package. Contact Craig Oien, M.D., or Terry Tone, Administrator, 134 Southview, Owatonna, MN 55060; 507/451-1120. (9/92-R)

Forest Lake Doctor's Clinic is seeking a BC/BE family physician and ob/gyn to join a growing 12-physician multispecialty practice. Located 25 miles north of Twin Cities in progressive community with excellent schools, outstanding recreational activities. Hospital located across street from clinic. Respond with CV or call Doug Sill, M.D., Harvey Frank, M.D., or Geoff LaGary, Administrator, 121 SE 11th Avenue, Forest Lake, MN 55025; 612/464-7100. (11/92-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Olmsted Medical Group is seeking BC/BE physicians in the following specialties: orthopedics, radiology, family practice, emergency medicine, and ob/gyn. Great opportunity for well-trained physicians to join a 55+ physician multispecialty group in a dynamic, progressive practice. In addition to the main office in Rochester, the group operates eight branch offices in southeastern Minnesota. Excellent salary/benefits package includes malpractice insurance, flexible benefits plan, 401(k) and profit sharing, and relocation assistance. Send CV to Olmsted Medical Group, Attn: Susan Schuett, 210 Ninth Street SE, Rochester, MN 55904. (1/92-R)

Wisconsin: 120-physician multispecialty clinic in the Fox River Valley of northeastern Wisconsin desires two BC/BE pediatricians to join department of 15 BC/BE pediatricians. Excellent compensation and benefits package, leading to shareholder status after two years. The community offers a superb recreational, cultural, and family environment in which to practice. For information please call or write Howard Kidd, M.D., La Salle Clinic, 411 Lincoln Street, Neenah, WI 54956; 414/727-4276. (3/91-R)

Family Physician wanted to join three board-certified M.D.s in well-established, expanding group practice. Weekend ER coverage. No buy-in. Financial package hard to beat. Enjoy a progressive, rural city within easy reach of St. Cloud and Minneapolis. Contact Dr. Jim Mohs, Melrose Clinic, 603 West Main Street, Melrose, MN 56352; office, 612/256-4228; home, 612/256-3488. (4/91-R)

Internal Medicine, Pediatrics, and Dermatology practice opportunities available at the Faribault Clinic. The Faribault Clinic is a multispecialty group practice of 19 physicians. Faribault is located 50 miles south of Minneapolis on I-35. For more information contact Ray W. Wood, M.D., or Ken Smith, Administrator, 924 NE First Street, Faribault, MN 55021; 507/334-3921. (4/90-R)

Stillwater: Twenty-physician multispecialty group with emphasis on primary care seeking BC/BE family physician. Scenic location with excellent school system, supportive medical community with strong local hospital, competitive salary and benefits. Send CV to Jon Pedersen, St. Croix

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Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

Family Practice, Surgeon: Five family practice group seeks surgeon, plus one or two family practice physicians. Population 8,000. One hour south of Burnsville Center. Lakes, industry, negotiable salary. Clinic adjacent to hospital. Ample free time to enjoy family life. Contact James W. Dey, M.D., or Ruth Hawker, Clinic Manager, 501 North State Street, Waseca, MN 56093; 507/835-3110. (9/93-R)

Mora, Minnesota: Aggressive, young, seven-physician family practice group seeks to add one or two physicians. Mora is a friendly community located one hour north of Minneapolis/St. Paul. There is abundant outdoor recreation in the area, including Mille Lacs Lake. The town is host to the Vasaloppet Ski Race, a half-marathon, canoe race, and bike

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Wisconsin—Internist Wanted: Group Health Cooperative, a progressive, growing, primary-care group practice in a city of 60,000—90 miles from Minneapolis/St. Paul—is currently recruiting a third BC/BE internist. Very competitive salary with excellent fringe benefits. Practice high-quality internal medicine in a most desirable location. Please contact James A. Volk, M.D., Medical Director, Group Health Cooperative, PO Box 3217, Eau Claire, WI 54702-3217; 715/836-8552. *3-3/94

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3609, or send inquiries to 7801 East Bush Lake Road, Suite 400, Bloomington, MN 55439. (*3/93-R)

Wisconsin—Family Practitioner Needed by progressive and growing group practice in west-central Wisconsin city of 60,000. Ninety miles from Minneapolis/St. Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high-quality care in a good recreational area. Send CV to James A. Volk, M.D., Medical Director, PO Box 3217, Eau Claire, WI 54702-3217; 715/836-8552. *3-3/94

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Mankato, Minnesota: Just added fifth FP, need sixth to join board-certified family physicians, aged 35-45, in fast-growing, full-range practice. Ob optional. Population approximately 40,000. Seventy miles to Twin Cities. Four colleges nearby. Subspecialty consultation readily available on hospital staff. Academic appointment available. Call Tony Giefer, M.D., 1695 LorRay Drive, North Mankato, MN 56003; 507/387-8231. (*9/93-R)

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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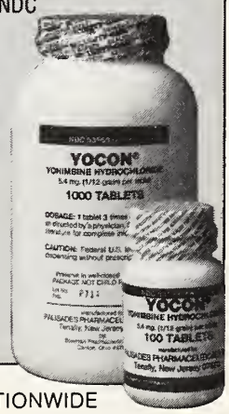

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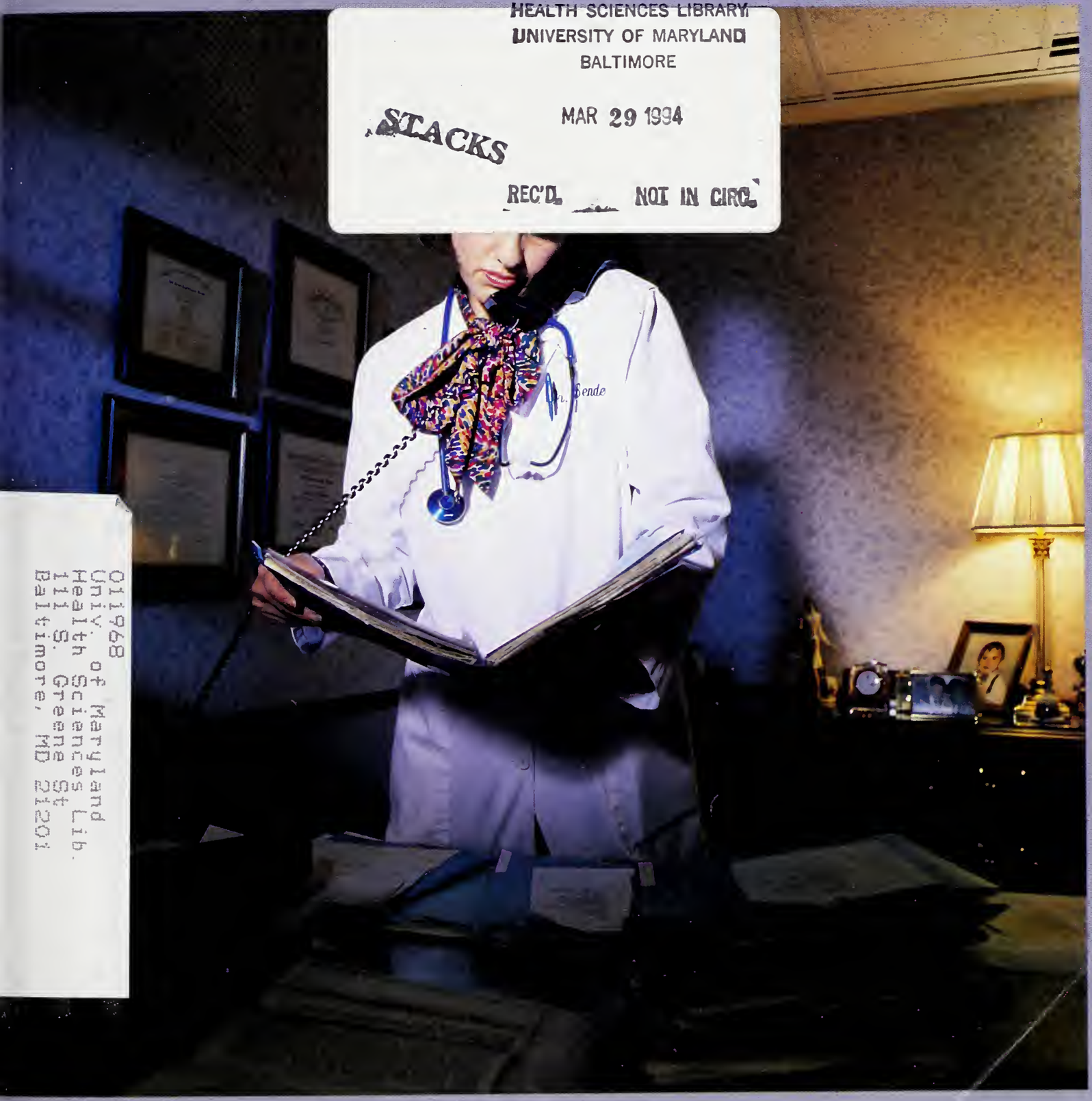

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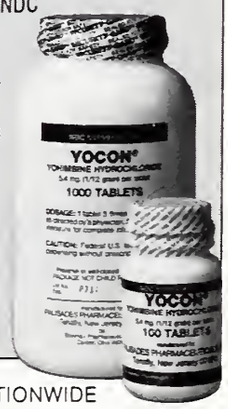

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Aggregate, Amalgamate, Affiliate

Can Small Shops Compete With Medical Wal-Marts?

Charles R. Meyer, M.D.

It's not easy being David with all these Philistines around. So might the biblically inclined Twin Cities physician think today. As health care organizations in our midst aggregate and agglutinate, practicing docs feel increasingly like incredible shrinking hulks with their autonomy and authority melting before their eyes. Perhaps physicians' previous control was more perceived than real, but it does seem that the health care market is crying "big is better" to the detriment of traditional practice. Three articles in this issue focus on the evolving medical marketplace and how solo doctors are responding.

In a sequel to a September 1992 *Minnesota Medicine* article, Doug Shaw and Tom Hoban describe developments in the Twin Cities health care market (page 16). The article's subtitles speak of amalgamation—"merger," "consolidation," "affiliation," "partnerships." Propelled by the forces of MinnesotaCare, business health care coalitions, and HillaryCare, large organizations are getting larger. We are entering the Wal-Mart era of medicine, where buyers of health care can one-stop-shop, purchasing doctors, hospitals, and a health plan under one roof. Organizational marriages, or cohabitation, which a few years ago would have seemed the illusions of a hashish smoker, are now a reality. The wedding of Medica and HealthSpan and the *ménage à trois* of Group Health, MedCenters, and Ramsey HealthCare look strange from as recent a perspective as 1985. These trends have hospitals and doctors scrambling to get bigger and gain clout.

But not all doctors. Todd Nissen's portrayal of solo practitioners in the Twin Cities and Fran Miller Toubin's profile of solo obstetrician Charles B. Crutchfield describe physicians not just surviving as independent doctors, but flourishing. Although the demands of time and cost are not easy, these doctors have chosen solo or small group practice because they value independence, close patient relationships, and a sense of control over their daily practice operations. They legitimately challenge the current mantra that large and integrated is cheapest. Any doctor who has covered for others knows about the inevitable inefficiencies of caring for an unfamiliar patient.

"The medical scene today resembles American business in the late 1800s, replete with trusts, mergers, monopolies, and, some would say, even robber barons."

In the past, such practitioners have sacrificed the collegiality and support of partners. In today's market, they risk losing major pieces of business if large players talk only to large players. The diversified portfolio of payers that Dr. Crutchfield describes may not be available in tomorrow's market. For small groups, unnerving, unanswered questions about health system reform include: What will determine patient choice of doctor? How will hospitals be chosen to "play"? How will specialists be chosen? How much influence will individual patients have on employers' choice of health plans?

What is a sound response for solo docs in today's medical scene? Getting involved and keeping an open mind to new business styles are a start. For even the most successful soloist, the tested tactics of effective marketing and high-quality, cost-effective care in a "small shop" may not be enough tomorrow. In previous years, patient choice of providers has been a potent force that derailed a number of proposals. But managed care is a buzzword whose buzz is getting louder, and not all variants of managed care include patient choice. To play in this game, small groups need not face death or serfdom as hospital or HMO employees. Nissen's article briefly describes the option of physician hospital organizations in which small groups can keep some of the desirable features of group practice but gain influence in the marketplace. The PHO movement—a topic we'll examine in our April issue—is exploding nationally.

The Twin Cities medical scene today resembles American business in the late 1800s, replete with trusts, mergers, monopolies, and, some would say, even robber barons. In this analogy, physicians are laborers. In the 19th century, laborers formed unions, organizing to improve the quality of their workplace. Physicians today may not need unions, but they do need to cooperate. In the Bible, David did slay the Philistine Goliath by himself. Today he may need a little help from his friends. MM

Solo Doctor's Medicine Reaches Many

Charles Crutchfield, solo ob/gyn and father of five, is a community leader in his spare time. He even grows peaches in his Minnesota garden. Just try to tell him it can't be done!

By Fran Miller Toubin

Charles E. Crutchfield, M.D., didn't set out to become a role model. Yet, when the Ramsey County Medical Society bestowed its Community Service Award on him at its annual meeting in January, that was the term used to describe the 54-year-old ob/gyn and father of five. "Dr. Crutchfield really is a role model for young people—especially young African-Americans," said Vernon Rowen, acting executive director of RCMS. "When you look at what he has done and continues to do, that's what comes shining through."

More concerned about making a difference than being recognized for it, Crutchfield says he is, nonetheless, flattered to be honored by his peers. "My wife tells me I am a role model in the community and that people know they can count on me," he says. "I really don't seek publicity, but I do enjoy serving my community."

A Community Leader

Crutchfield, who has a solo practice in St. Paul and is chair of the Ob/Gyn Department at United Hospital, is particularly active with youth in his community. He serves on the board of directors of B.T. Bombers, a local gymnasium aimed at keeping young people off the streets and off drugs. He is the boxing physician for amateur Golden Gloves and other teenage boxing clubs and performs camp physicals for underprivileged community children at the University of St. Thomas each summer. In addition to participating in his own neighborhood church, he often gives speeches at other churches in his community and lectures routinely on AIDS and other sexually transmitted diseases, drugs, birth control, and other topics to young people in community, church, and school groups. Also active in the local Remember Rondo Days, an annual commemorative celebration in St. Paul's African-American community, Crutchfield had the distinction of being named one of the 50 most influential African-American leaders in his community in the past 150 years.

A Family Man at Heart

For more than 16 years, Crutchfield and his wife, Pat, a local newspaper columnist, free-lance writer, and community activist, have lived in the Central Village (inner-city) area of St. Paul. Crutchfield says they love their heritage and wanted their kids to have exposure to other African-Americans. He beams when he talks about his teenage son, Rashad, and daughter, Raushana, and about his three older sons: Charles III, a senior at the Mayo Clinic; Carleton, a practicing attorney in Minneapolis; and Christopher, a freshman law student at the University of Minnesota. (He describes his granddaughter, Mahogany, 2, as his joy.) "Out of everything I've done," he says,

PHOTOGRAPH BY BRUCE BAIRD

"There will always be a few doctors like me who don't want to graze with the herd."

"I am most proud of my role as a father."

Crutchfield credits his own father with inspiring much of his success. "My dad always said, 'Just do the best you can, and if you know in your heart that you've done your very best, then that's good enough,'" says Crutchfield. "Most people can't honestly say they've tried their hardest, but I've tried to live by that advice and teach it to my kids."

A native of a small town near Birmingham, Alabama, Crutchfield says he was "raised poor" and "even picked cotton." He was initially inspired to pursue medicine by a compassionate family doctor who came to his house to administer penicillin when Crutchfield contracted pneumonia at age 6. Because Crutchfield's father believed his son would have greater opportunities in the North, he sent him to Minneapolis to live with relatives during his senior year of high school.

He worked his way through the University of Minnesota, graduating in three years. After earning his medical degree from the university's medical school, Crutchfield interned at Ancker Hospital in St. Paul, where he was voted Intern of the Year. He then completed his ob/gyn residency at the University of Minnesota.

Crutchfield served in the Air Force for two years and, at the age of 28, became chair of ob/gyn at Fairchild Air Force Base near Spokane, Washington. He earned a special commendation from the Air Force based on a vote of his peers before returning to Minnesota in 1969 to become the first practicing African-American ob/gyn in the state.

A Physician of Color

Because he believes that health care decision making must involve "someone who has been there and knows and understands the minority and underprivileged communities," Crutchfield has taken an active role in local and state medical associations. As president of the state chapter of the National Medical Association (a professional organization for African-American physicians), he has worked to build membership and is proud that last year the NMA awarded six medical school scholarships to African-American students. He also sits on the Minnesota Medical Association's Committee on Minority Affairs, where he is able to voice his concerns on behalf of minority patients, physicians, and clinics.

"Many of the minority physicians—who have traditionally provided care to their communities—have solo or small-group practices," says Crutchfield.

CRUTCHFIELD continued on page 46

A Buzzing in the Ear

by S. Horatio Slawson

When a young girl arrived at the ED with a curious and unusual condition, this medical student found his training didn't hold the answers.

ILLUSTRATION BY GLENN QUIST

It was the last month of my fourth year in medical school and the match results had already been posted; my classmates and I knew where we were going, and there was a sense of relief, letdown, and relaxation. We had chosen our electives for the fourth year late in our third year, and others in my class had more wisely chosen statistics, epidemiology, or a month-long externship with their local community doctor, allowing them lunches at home, as many afternoons off as they dared request, and significantly reduced commuting time into the city.

Five days before graduation I was doing the emergency room rotation at the largest public hospital in Washington, D.C. I had on my short coat—neatly pressed, creased, and white—and my pockets were filled with a tuning fork, stethoscope, multiple charts and handbooks, and a portable otoscope and ophthalmoscope. Gravity pulled the jacket's bulging side pockets outward and down, stretching the shoulder seams apart.

This particular Saturday evening in late May was hot and sticky. I had the 3-to-11 shift. I must have seen 20 to 30 patients that night, but I best remember the tiny, five-year-old girl with tightly woven braids.

"Hello," I said as I entered the cubicle and closed the curtain. She perched on the examination table, her hands tucked underneath her legs, leaning forward. Her head was cocked to one side, and she was smiling.

Her father sat in the plastic chair in the corner. He was still dressed in heavy blue work coveralls with grease stains on the legs and arms. "Hello," he said, firmly shaking my hand. His hands were deeply callused, his knuckles large and scarred, and beneath his finger nails was a blue-black collection of oil and dirt.

"What brought you in?" I asked. The young girl glanced quickly over to her father and then back to me, again smiling shyly.

"Bug in the ear," her father said.

The girl tilted her head to the right and slapped the flat butt of her hand against her right forehead as if trying to dislodge drops of water from the inside of her ear.

"How do you know it's a bug?" I asked her.

She grinned, " 'Cause it keeps buzzing."

"Must have crawled in," her father said. "Q-tip didn't work. Water didn't work. Now she can't sleep, can't hear well in school. It keeps tickling, walking, buzzing, and flapping around in there."

With my otoscope I examined both ears, beginning

with the unaffected left side. She had cerumen build-up on the left, but it was otherwise normal. In the right was cerumen as well, but directly adjacent to the tympanic membrane, its wings dusted with wax particles, was a medium-sized roach.

I took a lengthy history, asking about prior surgeries, ear infections, drug allergies, and so on. I tested the girl's hearing, which was sharp bilaterally. She was afebrile. The standard abbreviated physical exam was negative.

"Bug in the ear," her father said confidently.

"Yes," I nodded curtly.

I took my penlight from the breast pocket of my jacket and depressed the clip handle, and with the thin light beam, I took a second look at her right ear.

The girl's father sat up in his chair, his eyes on the penlight. As an auto mechanic, he seemed to appreciate its utility, its light weight, ease of handling, and its pencil-point beam. I could see that he was considering the possibilities: shining the beam down the deep valves of a carburetor or lying on his back directing it upward into the recesses of the engine manifold. I had received it free as part of a pharmaceutical advertising campaign.

"I was sweating now and I stood back, my hands on my hips, thinking furiously."

I stepped out into the hallway and checked all the chapters in the ENT books. They contained references to foreign objects in the ear but no discrete references for insects in the ear canal. I tried to talk with my supervisory attending, but he was busy with a code. I cornered the resident on duty, but he was suddenly called away when the paramedics wheeled in a gunshot victim. I was on my own. At first I tried rinsing the ear with normal saline and a cerumen removal tip. The girl winced slightly when the jet of water surged inside her ear. Afterwards, with my otoscope, I could see a wet and soggy, but unmoved and very much alive, roach. I tried again, same technique. Same result.

I grappled the bug with a small ear hook. He twitched his head and flapped about, changed positions, and avoided the hook. Once the hook pricked the sensitive skin along the girl's external ear canal, and she winced. I was sweating now and I stood back, my hands on my hips, thinking furiously.

"That light might come in handy now," said the father. Confused, I looked over at him.

He glanced down at my clipboard with the long, legal-sized white sheets of paper, all neatly lined with spaces and figures for entering lab values and results of physical and clinical findings.

"Got any more of those?" he asked, indicating the sheets of paper. I handed him one. He rolled the paper up lengthwise and placed it against his eye, glancing around the room and then at me through the long, hollow tube. Standing up, he pressed one edge of the tube against the girl's ear, and with his left hand, he pushed against her right forehead, cocking her head downward to the right with the tube angled toward the ground. He tightened up the tube so its far end was the size of my penlight.

"Put that light up against the end, and turn it on," he said. I did so.

"Let's keep the light on, and be quiet, and then see what happens to old Mister Bug," he suggested.

After a couple minutes, I could hear the rustle of the bug and the flapping of its movements as it crawled out the ear canal toward the far shining light. I could feel the rustle of its legs twitching against the smooth paper. The father could feel it, too, and with a quick pincer movement of his thumb and forefinger, he squashed the roach inside the paper tube. He had cured his daughter. She smiled and laughed all at once, "It's out!"

I was pleased, and abashed. Quickly, I gave them instructions on care for the ear canal to prevent infection and described signs and symptoms to watch for. I gave them instructions on completing the paperwork and exiting the emergency room, and then I quickly left the room, gathering my utensils into my pockets.

"Thank you," he said, shaking my hand firmly again.

"You're welcome," I said, relieved to be leaving.

Once outside the room, I escaped into the chart room to complete my examination notes. I could see the small girl and her father standing in line at the billing desk. Surreptitiously, I watched. The man took the completed statement, counted out several bills, fives or tens I think, and paid the remaining amount with a check.

Quickly, I gathered my notes and went to the lobby.

"Excuse me," I said as I walked up to the pair, nudging the father's arm. "If this happens again, you'll need this," and I held out the penlight. It had been free, and I had not appreciated its full value. He had. His eyes narrowed; he looked down at the penlight and then back at me. His daughter held his hand and smiled up at me.

"For the bugs?" he asked.

"Yes," I said. "Works very well," I added seriously.

His face softened, and he smiled. He took the light, scooped the little girl up into his arms, and they walked out into the night. MM

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Successfully Solo

Under pressure to link up with larger groups, solo and small practice docs say bigger is not always better.

by Todd Nissen

PHOTO BY ROB LEVINE

Each day, between office visits and rounds at Methodist Hospital, oncologist Gail Bender sees anywhere from 17 to 30 patients. She does this five days a week, working from 7 a.m. to 4 p.m., and she spends about three hours Saturday and Sunday seeing patients in the hospital and finishing paperwork. She's always keeping a close eye on expenses, and, like most physicians, she's spending considerable time dealing with payers. Unlike most of her colleagues, she's in business for herself.

The life of a solo practitioner may be busy, but for Bender, it's the best way to deliver medicine. "We're busy because we provide a service that people in the community desire—personal care," says Bender, who has been in solo practice since she started in 1982. She knows her patients and her patients know her. Thanks to a beeper and a portable phone, they can reach her 24 hours a day, seven days a week. Whether she's at a ball game or Byerly's, she pledges to do what she must to take care of her patients.

"Personal care is always available. When my patients are ill, I'm there to hold their hand. That's a form of medical care that never goes out of style."

As a doctor, Bender sees herself as her patients' health advocate. She sticks up for them when payers balk. She doesn't hesitate to dicker with insurance firms over the phone or through letters. Indeed, Bender, who also is a director of Medica, is unequivocal about where her loyalties lie. "I want my patients to get appropriate, state-of-the-art cancer care, and I'll go to the mat and fight with insurance companies to make sure they get that," she says.

Bender's solo practice is thriving in an age when many other solo and small practices are being swallowed up by larger groups and hospitals. Numerous observers and trade journals refer to Bender and others like her as a dying breed. Solo practitioners and physicians in small groups are the dinosaurs of the modern health care system, many contend, heading for extinction in the tar pits of health care reform.

Reform isn't the only hurdle they face. Maintaining access to patients is increasingly difficult. Employers want to buy care for their workers from a few large groups, not dozens of small clinics. Insurance payers are trying to control their costs by curtailing the number of providers they have under contract. Often, that means dropping the small operations. Whether they are HMOs or President Clinton's proposed regional health alliances, large groups are becoming the order of the day.

"I would not start a solo practice, or even a two- to three-man group in a large metro area, because I think you have to belong to an organization to compete," says Richard Reece, M.D., a former Twin Cities physician and past editor of *Minnesota Medicine* who is active in forming physician-hospital organizations around the country. Reece is currently chair of Deaconess Clinical Associates, a physician-hospital organization in Oklahoma City.

For the record, many physicians who choose solo practice adamantly deny they are dinosaurs of modern health care. Steven Saliterman, an internist for 13 years in Minneapolis, is living proof that extinction is a long way off. "Small clinics that have adapted to the changing medical environment compete very effectively with the bigger clinics, largely because of their ability to control overhead, rapidly introduce technologies, and ease access for patients," he argues.

According to Saliterman, many people's image of a solo doctor is one of an old-fashioned physician out of touch with the modern world. Although it is getting more difficult, Saliterman and others maintain that high-quality, cost-effective care can be delivered just as well—some argue better—in small groups as in a large clinic with a capitated pay system. "There is a misconception that care delivered in small clinics is too costly, variable in quality, or old-fashioned. None of these has been proven. Small clinics can effectively compete in bids for clinical services, track diagnoses and outcomes, and apply unparalleled flexibility in adapting to patient demands," says Saliterman, pointing out that he uses computers in his practice for diagnosis database management, literature retrieval, and claims processing.

> "I want my patients to get appropriate, state-of-the-art cancer care, and I'll go to the mat and fight with insurance companies to make sure they get that."
>
> –Gail Bender, M.D.

Small clinic doctors believe they offer another crucial benefit: choices for patients and referring physicians. Mark Stesin, M.D., has a two-person endocrinology practice with office locations in Robbinsdale, Coon Rapids, and Minneapolis. In January, he was featured on the cover of the lifestyle magazine *Mpls.St.Paul* as one of

the best doctors in a survey of nearly 2,700 physicians. Among other things, this demonstrates that patients and physicians appreciate Stesin's personal style of practice—a style he believes should remain available to those who want it. "I think patients need choices. Some people might feel more comfortable in a big clinic setting, while others feel more comfortable going to a smaller clinic," he says.

In fact, independent research bears out many small practitioners' claims. A study by *Medical Economics* trade journal last October found an initial office visit to a practice of 50 or more doctors costs an average $125—39 percent higher than the average $90 solo practices charge. The survey showed similar results for visits by established patients, who were charged $50 by the large practices and $40 by solo practices.

BRIAN PARMETER

Solo internist Steven Saliterman

Last August, the *Journal of the American Medical Association* published results of a three-city study that showed higher patient satisfaction for small or solo practices than HMOs. The government-sponsored study was based on interviews with more than 17,000 patients in Boston, Chicago, and Los Angeles in 1986 and updated in 1990. It found that patients were more likely to be satisfied with the explanations of small clinic physicians, that independent doctors were easier to reach by telephone, and that those doctors showed more interest in patients' well-being than physicians in HMOs or large multispecialty practices.

Despite such success, those alone or in small groups recognize that their world is changing. With annual cost increases far outpacing inflation, the pressure for cheaper alternatives is intense. Managing a doctor's office is no longer a cottage industry. The daily practice of medicine is being nudged ever closer to the maw of big business.

George Halvorson, president and chief executive officer of Bloomington-based HealthPartners, the largest HMO in the state, says there is nothing inherently substandard about solo practices. The problem, he says, is the wide inconsistencies between individual clinics.

"A given solo practitioner may be absolutely brilliant and delivering world-class care. And the next medical practitioner down the road may not have read a journal in two years," he says.

Nonetheless, Halvorson contends there is still room for solo and small practices in the future. However, they will have to adapt to the "best practice" standards managed care systems are demanding. "I don't think it's impossible to design a care system model that utilizes the solo practice model," he says. "I think it's more difficult to create efficiencies and create consistency in that model—but I think it's doable."

William Jacott, M.D., assistant vice president for health sciences at the University of Minnesota and a family physician, also says there is a spot for solo doctors. Some specialties, such as ophthalmology, dermatology, and plastic surgery, lend themselves to small clinics, where overhead and after-hours call are minimal.

The demands of a family practice are another story, though. In a sign of the times, Jacott says none of the 44 family practice graduates he interviewed coming out of the University of Minnesota in 1991 planned to enter a solo practice. Numbers provided by the Minnesota Medical Association tell a similar story; just 504 of Minnesota's 8,080 practicing physicians are in solo practice.

The reasons so few physicians enter solo practice are many, say Saliterman and Bender. For one, training programs often dissuade students from joining small or solo practices, sometimes painting a bleak and misleading picture about the chance of survival, says Saliterman. In addition, he says, "Nothing in medical school prepares physicians to run a business. There's no entrepre-

neurial training, which is unfortunate." Concerns about the financial and time commitment needed to start a new practice also make solo practice unattractive to medical school graduates, most of whom are already burdened with large loans.

Bender points out that many young physicians are worried about negotiating with third-party payers. "You have to know how to interact with payers, and many physicians fear they may be excluded. It can be scary to hang your shingle and be on your own." Nonetheless, Saliterman and Bender both express great satisfaction with solo practice. "The advantage is I make all my own decisions," says Bender. "If I want to buy equipment or take time off, I don't consult with a partner. Being on my own is great—it's the right thing for me." Both Saliterman and Bender say that handling call and finding coverage for vacations add no extra stress to their practice. Both have arrangements with other physicians for vacation coverage, and call is limited since they handle only their own patients.

But health care reform is bringing many changes to medicine, and solo and small group physicians are responding in a number of different ways. Some plan to stay the course and remain independent—at least for the time being. Others are not waiting to find out what direction the future takes. Many are quitting their practices to join larger clinics, forcing their partners to consider other options. Others are linking up with independent physician networks or the new physician-hospital organizations. Still others are free-lancing, picking up work where they can.

BRIAN PARMETER

Oncologist Gail Bender

Bender thinks she has hit upon a solution that works. It is a mixture of highly personal patient care, shrewd marketing, and sharp business acumen. During office visits, Bender asks in three different ways if patients have any questions about their care. She gives speeches to schools, churches, and clubs. She keeps up with research developments in her field by attending two to four professional meetings a year.

"Every activity you do is a marketing activity. I'm not talking about billboards. I'm not talking about fliers. I'm talking about how you interact with patients and doctors," she says.

Bender, who practices in the Meadowbrook Medical Building in St. Louis Park, also keeps close tabs on her expenses and tries to run a lean office with three full-time equivalent employees. Bender's overhead was 37 percent when she started. It now stands at about 50 percent, mostly because the administrative costs associated with practicing medicine have skyrocketed. Still, that is less than the overhead with which many large multispecialty groups operate.

Saliterman, a primary care internist, attributes his durability to sticking with the basics of personal, high-quality care. Like he did when he started 13 years ago, Saliterman takes all his own call. His support staff is 1.7 full-time equivalents. In fact, Saliterman argues he is more efficient than larger providers. As a solo physician, his earnings are tied almost exclusively to his own practice skills—not the x-ray and lab services that large groups offer.

Saliterman's methods obviously work. His practice is profitable and has about 5,000 active patients. Outside of Park Nicollet Medical Center, he is the only primary care internist in St. Louis Park. Saliterman has outlasted eight independent primary care clinics, mostly one- to three-doctor groups, which succumbed to retirements, mergers, or a failure to draw patients.

But external pressures are taking their toll. Last fall, for the third year in a row, Johns Hopkins Medical Institutions in Baltimore asked Saliterman to lecture at a critical care conference as an invited faculty member. When he returned to the Twin Cities, he learned he was ineligible to participate as a primary care provider in the Blue Plus HMO because of his solo practitioner status.

Despite Saliterman's protests, a representative of the HMO refused to send him an application. The reason: solo physicians are excluded as a general policy—regardless of their credentials.

"I would say that was the most discouraging experience of my career," says Saliterman.

John Dowdle, M.D., an orthopedic surgeon in St. Paul, spent nine years with a 10-physician clinic before striking out on his own in 1988. This January, after five years as a solo practitioner, he merged his practice with four other doctors.

Dowdle didn't make the move because he was losing money or needed better economies of scale. Indeed, his overhead as a solo physician was 28 percent—down from 72 percent at his former 10-person office. Dowdle said he joined the other physicians in order to respond to the group buying patterns that employers are implementing.

"I think the key for the future is going to be to hook into a larger organization that can represent or market you," he says. "With the large buyers directing patients where they can and cannot go, it's almost like you need an agent to represent you and your practice to the buyers."

Dowdle and his new partners could present a blueprint for how to form a group in the current environment. With five physicians, their group, called Landmark Orthopedics, is not large. But what it lacks in numbers it makes up in connections to payers. Dowdle sits on Medica's board and does consulting work for Liberty Mutual Insurance Group. Two of his new partners do work for Blue Cross, while another works with a workers' compensation insurance firm.

"Together, the five of us have our fingers in a lot of places," he says.

Like Dowdle, his new partners all have experience running efficient operations. Separately, each one had overhead below 30 percent. In fact, Dowdle maintains that smaller groups are more proficient than larger practices at holding down certain expenses.

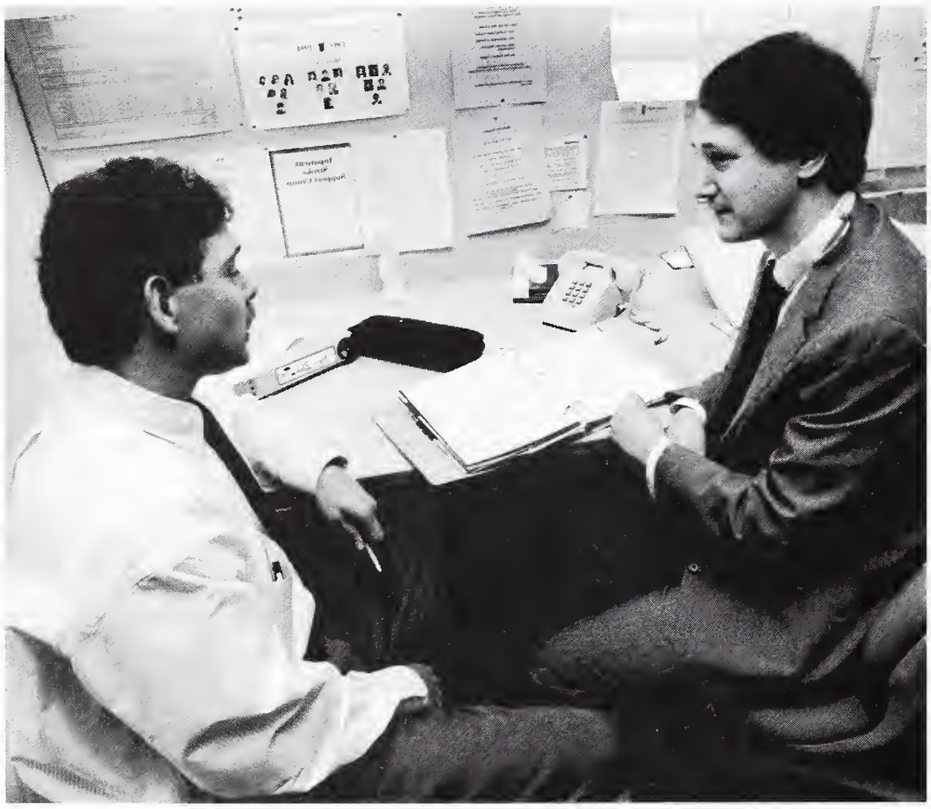
"I think doctors, when they get in a larger group, expect to be waited on. It's less their show. It's part of the corporation. They think it's OK that everything is handled for them, and that they shouldn't be bothered with the mundane things of life."

The physicians of Landmark Orthopedics are also like-minded in their practice styles. As more and more physicians merge or form new groups, Dowdle believes many are not considering their style differences.

"There are some Northwest-Republic-type mergers going on out there. Some practices are patient-oriented, others are technology-oriented, and they're trying to put two cultures together and work that out," he says.

Richard Simmons, M.D., and Leonard Parsons, M.D., are two examples of small group physicians forced to make change. Parsons, a family physician in Minnetonka, was left on his own late last year when his partner joined Park Nicollet Medical Center.

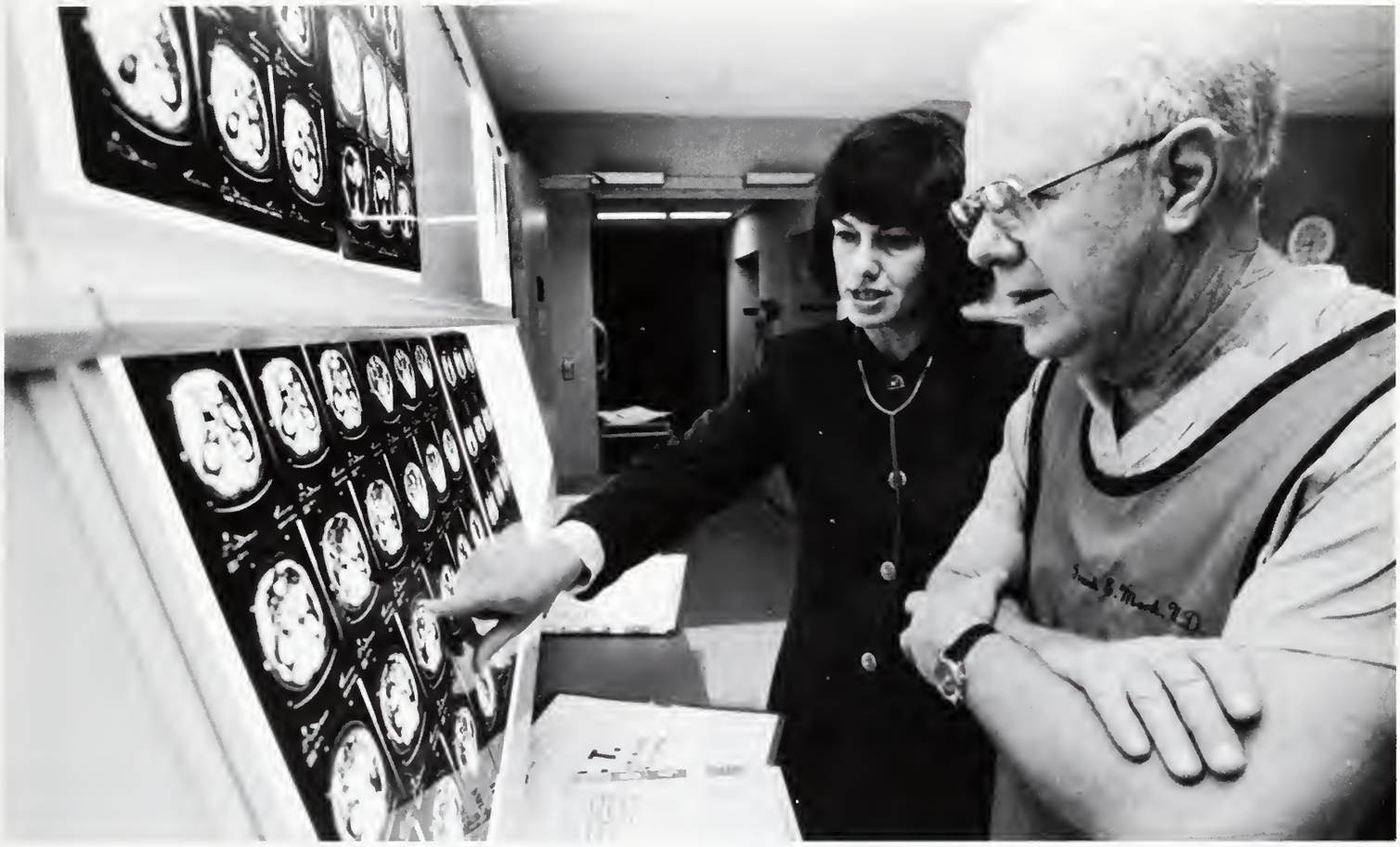
Parsons, 53, would prefer to stay on his own. He likes the dynamics of a small practice and the opportunity to develop close, long-term relationships with his patients. But like others, Parsons knows that employer buying coalitions don't want to deal with numerous small clinics. Moreover, the Legislature has yet to hammer out the final rules governing integrated service networks, including how far ISNs can go in excluding physicians.



BRIAN PARMETER

Given that, Parsons says there is a good chance he will move his practice to a network being organized by HSM Associates, a member of HealthSystem Minnesota. "If I knew what things are going to be like for the next couple years, I'd stay where I'm at. But I don't know," he says.

Simmons found himself in a similar bind last fall. A Bloomington family doctor, Simmons joined the Penn Avenue Medical Group in December 1958. In October, the practice shut its doors after the youngest of the three physicians decided he needed more long-term job security than the



BRIAN PARMETER

group could provide. Simmons and his partners tried several approaches to save the practice. They searched—unsuccessfully—for a young physician to join the group. They shopped the clinic to Methodist Hospital, the Fairview system, and HealthSpan Health Systems Corp. With favorable demographics, a good location, a 99 percent collection rate, and high patient loyalty and satisfaction, the clinic seemed like it would make an attractive purchase. Nobody was interested.

The group also explored an affiliation with a large, multi-site practice, but the deal they offered was not financially acceptable. "We finally just gave up and closed October 1," Simmons says.

Both Simmons' partners have joined larger clinics. After a four-month search for a part-time position, Simmons, who is 63, joined France Avenue Family Physicians, where he is working three days a week without call. During his search, he saw patients at an urgent care facility, working as what he calls a "doc in the box."

If they are going to survive, solo and small group physicians might have to find a way outside of patient relationships to justify their skills, says Reece of Deaconess Clinical Associates. There is much to be said in favor of physician-patient rapport, Reece says, but the sacredness of such relationships does not go far with payers, who are looking for concrete systems to document quality.

Ultimately, the decision to remain on their own may come down to the personal preference of the physicians themselves. When speaking about physician-hospital organizations, Reece tells physicians: "There is a certain joy to being a solo practitioner—being in control of your own destiny, having patients adore you. But there is also a certain joy—an equal joy—in being in a winning organization and being part of a team providing innovative and creative services."

For her part, Bender urges new physicians to consider solo practice an option. "If you want to be a solo doctor in the year 2010, it's possible. You'll be busy—you'll have to market yourself and learn about financing; you'll have to keep updated; and you'll need to manage people in an office setting. But if you want to do it, you can—just look at Saliterman, Stesin, and me. We've succeeded." **MM**

Todd Nissen, a former free-lance writer, is now working for Reuters News Service in Chicago.

Health Care Trends Revisited

By Douglas A. Shaw and
Thomas W. Hoban, M.S.P.H.

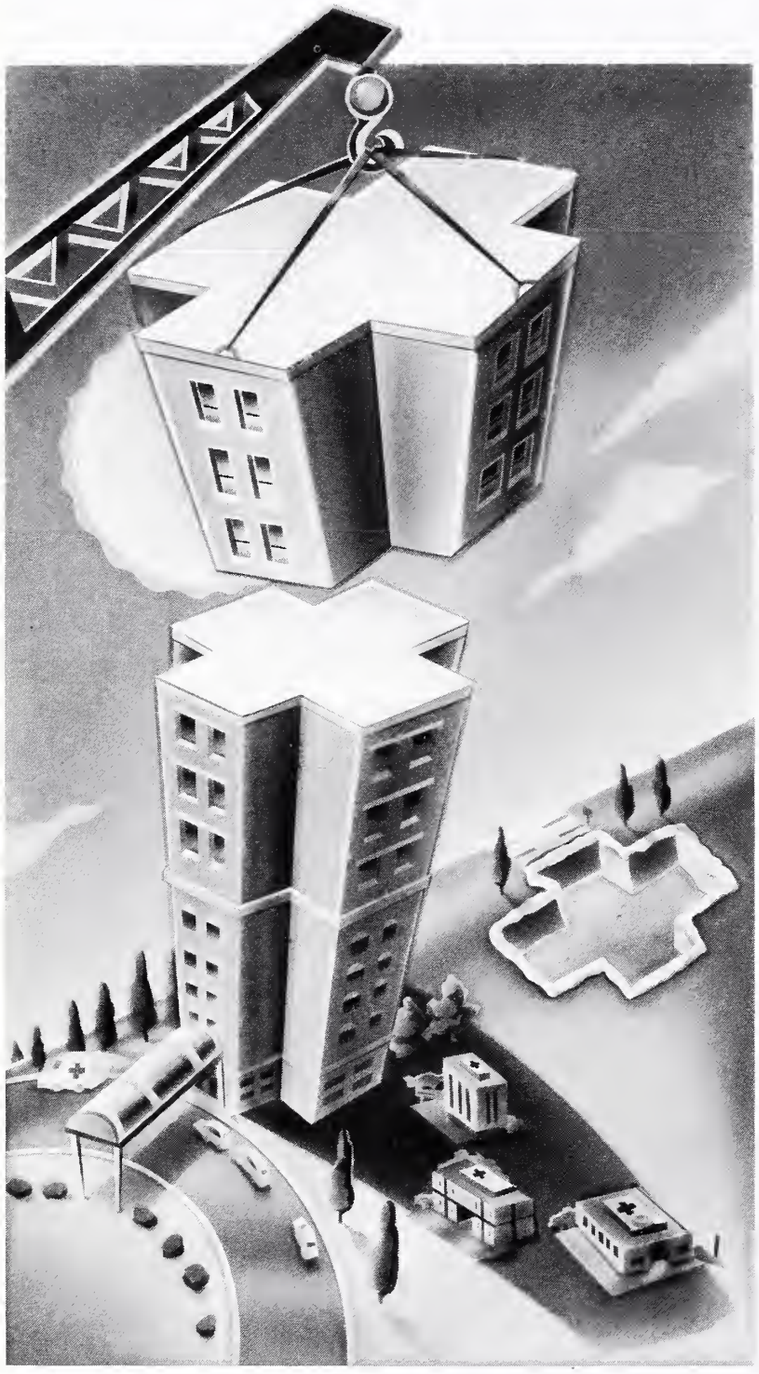


ILLUSTRATION BY CINDY LINDGREN

The Twin Cities health care marketplace is changing rapidly, with implications for independent physician practices.

The Twin Cities health care marketplace is changing at breakneck speed—so fast that many physicians feel caught in a whirlwind of confusion. As *Minnesota Medicine* Editor-in-Chief Charles Meyer, M.D., said in a recent issue, "Comprehending HMOs and PPOs was tough enough, but these are becoming archaic, shoved aside by the latest acronyms: ISN, PHO, IHA. Three-letter words are rapidly supplanting four letters as obscene in the minds of physicians."

Twin Cities groups are forming new collaborations to prepare for integrated service networks (ISNs) almost daily, and large mergers and affiliations are creating an ever-more consolidated marketplace. HealthPartners, Allina, HealthSystem Minnesota, and HealthSpan are just a few of the new names that have

entered the scene since we last published an article on health care trends in *Minnesota Medicine*, about 18 months ago.[1]

In that article, we identified major developments underway that have significant implications for independent physician practices. These included:

- health plan, large multispecialty group practice, and hospital system consolidations into fewer large payer and/or health care delivery organizations;
- the dominance of managed care in the Twin Cities;
- the development and influence of employer-sponsored "buyer coalitions";
- the growing role of the public sector—both at the state and federal level—and its impact on the organization, financing, and delivery of health care services;
- the emergence of data systems as an increasingly important tool for measuring the cost, utilization, and outcomes of health care services.

Now, less than two years later, we find it necessary to once again assess the implications of a rapidly changing health care environment for independent physician practices.

We are awestruck by the rapid pace at which changes in the Twin Cities health care system continue to occur. The major trends identified above continue to dominate the health care scene but are taking on much greater clarity as mergers and other health care alliances are announced and health reform initiatives evolve. In fact, the most recent developments have probably set the health care landscape for the Twin Cities well into the next century.

Mergers and Other Affiliations

Numerous mergers and other health care affiliations have taken place in the Twin Cities in recent months. We have seen mergers and consolidations of the hospital systems serving the Twin Cities; the amalgamation of one of the area's largest multispecialty group practices with a full-service hospital; the merger of health maintenance organizations (HMOs) with hospital systems; new partnerships between large group practices and a major health plan; and the emergence of numerous physician-hospital organizations and other physician-directed delivery systems. Concurrently, hospitals have aggressively sought to acquire physician practices.

Hospital consolidations

The private hospital system in the Twin Cities now consists of three multi-hospital systems—HealthSpan (formed by the merger of HealthOne and LifeSpan), Fairview Health System, and HealthEast. Only North Memorial Medical Center, Methodist Hospital, and a few specialty hospitals and smaller hospitals serving outer-ring suburbs remain independent (see table, page 18).

Hospital/group practice consolidation

A consolidation of Methodist Hospital with the 350-physician Park Nicollet Medical Center in 1992 created the first private, integrated health care system of this type and size in the west-metro area. Subsequently, this new organization, known as HealthSystem Minnesota, announced a partnership with Blue Cross and Blue Shield of Minnesota to develop and jointly operate an ISN under new health reform legislation known as MinnesotaCare. This partnership will be well positioned to provide care for major self-insured employers.

Hospital/HMO mergers

Some of the most dramatic and far-reaching developments have been mergers involving hospitals with HMOs. First, HealthPartners (the merger of MedCenters Health Plan and Group Health, Inc.) entered into an agreement with Ramsey HealthCare, Inc., to acquire a large teaching hospital (St. Paul-Ramsey Medical Center) and its affiliated multispecialty group practice. This strategic move created ripples throughout the community as the HealthEast hospital system and private practice physicians in the east-metro area speculated whether their long-standing contracts to serve HealthPartners enrollees would be disrupted. The implications of this development may be of critical importance to HealthEast, which earlier severed its affiliation as a contracting Medica Choice hospital and recently announced plans to cut 300 jobs and convert Divine Redeemer Hospital to a long-term care facility.

HealthPartners, with its 575,000 members, has also kept hospitals and physicians in the west-metro area of the Twin Cities alert by indicating that it soon expects to announce its "west-metro hospital strategy." Currently, the campus of Riverside Medical Center (formerly Fairview and St. Mary's hospitals), the principal hospital used by the Group Health medical staff, serves as the site of a major Group Health clinic. The local media have reported that HealthPartners is carrying on discussions with both the Fairview Health System and Methodist Hospital about some form of affiliation.

More recently, HealthSpan, the area's largest hospital chain, and Medica, the state's second largest HMO, with approximately 550,000 members, announced plans to seek regulatory approval to merge under the name

Table

The new order of private Twin Cities hospitals

HealthSpan	Fairview	HealthEast
Abbott Northwestern	Fairview Ridges	Midway
Children's of St. Paul (seeking merger with Mpls. Children's)	Fairview Southdale	St. John's Northeast
Mercy	Riverside	St. Joseph's
United		Divine Redeemer (planning to convert to long-term care facility)
Unity		
St. Francis (Shakopee)		

Independents	Closed
Minneapolis Children's	Abbott
Gillette Children's	Bethesda Lutheran (long-term care)
Lakeview Memorial (Stillwater)	Eitel
Methodist	Fairview Deaconess
North Memorial	Golden Valley Health Center
Ridgeview (Waconia)	Metropolitan-Mount Sinai
	Mounds Park
	St. John's Eastside

"Allina." This merger will bring together a delivery and financing system of enormous proportions, with strong, historical ties to the private physician community. Under the joint leadership of Gordon Sprenger and K. James Ehlen, M.D., Allina will create a health care organization with approximately $2 billion in annual revenue, with hospitals throughout the Twin Cities and greater Minnesota, with state-licensed HMO and PPO programs, and a variety of other vertically integrated health care services.

Medical group/hospital/health plan partnerships

Blue Cross-Blue Shield has been most aggressive in its initiatives to establish strategic alliances with larger, multispecialty group practices and hospitals throughout the state. These developments include the formation of ISN joint ventures with HealthSystem Minnesota, (the merged Park Nicollet Medical Center-Methodist Hospital organization), with Affiliated Medical Centers in west-central Minnesota, and with the Dakota Clinic in northwestern Minnesota. Most recently, the Blues announced that it is establishing a partnership in the Twin Cities with the Fairview Health System and University of Minnesota health care system to operate an ISN. The recent affiliation of Aspen Medical Group, a 120-physician multispecialty group practice with historical ties to Medica, with the Blues also sends strong signals to physicians in private practice. Traditionally, the Blues has offered physicians in smaller, independent practice settings an important vehicle for marketing their services. Although the Blues has made no public announcement about its intent, a fundamental change seems to be occurring in its contracting strategy.

A related initiative by the Blues will be of great significance to many Minnesota physicians. Blue Cross-Blue Shield has announced its intent to begin contracting with limited numbers of physicians and hospitals in certain high-cost, high-tech areas of medicine. Coverage for designated health care services will be restricted to services rendered in, or coordinated by, "centers of excellence" selected through a rigorous evaluation. The first such program, involving cardiac surgery, is already in place, and others will follow. Physicians and hospitals not selected for inclusion in these limited networks will lose access to large numbers of patients.

Physician-hospital organizations

Virtually all hospital systems serving the Twin Cities have initiated extensive efforts to develop physician-hospital organizations (PHOs) to compete for patients by offering integrated health care services to selected purchasers. Generally, the structure selected for these organizations has been a tax-exempt foundation, with assets contributed by the sponsoring hospital system. The sponsoring hospital then serves as the corporate member of the PHO, selecting the members of its governing board. Physicians enter into contracts with PHOs to provide care to PHO enrollees and to provide medical input regarding the PHO's operation.

Physicians whose practices span two or more hospital systems became increasingly concerned as hospitals began to discuss the possibility of requiring exclusivity to participate in their PHOs. Eventually, the hospitals softened this position, allowing individual practices to designate a portion of their members as "committed" physicians, who would only see enrollees of a particular

PHO. Their physician colleagues, however, could continue to contract with competing PHOs and others without restriction.

Medica has repeatedly assured physicians that its pending merger with HealthSpan will not result in health plan offerings that restrict patient choice to those physicians and facilities affiliated with HealthSpan and its newly formed PHO.

Other emerging delivery systems

Hospitals are not the only organizations developing new health care delivery systems to serve the Twin Cities. Physicians themselves have been actively involved in the planning of new "clinics without walls,"[2-4] a concept developed through a joint task force of the Minnesota Medical Association and the Hennepin and Ramsey county medical societies.

In addition to a long-standing physician network in St. Paul known as the East Metro Health Organization, at least five other physician-sponsored networks are under development. The largest of these is Criterion HealthCare Network, which has announced plans to commence operations during the first quarter of 1994 with a metro-wide network of approximately 600 physicians. A similar organization being developed in the northern suburbs of Minneapolis is called North Area Physicians, Inc., and is supported by approximately 350 physicians, most of whom are members of the medical staffs of Mercy and Unity hospitals.

More recently, an organization known as the Primary Service Network, sponsored by a number of primary care-based medical groups throughout the Twin Cities, announced its intent to organize and seek contracts with employers, health plans, and others to provide health care services to employees or members. PSN has said that its primary care physician base consists of more than 200 physicians.

"Virtually all hospital systems serving the Twin Cities have initiated extensive efforts to develop physician-hospital organizations."

Also of interest is the development of two networks of referral specialists, one based principally in the west-metro area, known as Minnesota Specialty Physicians, and the other based principally in the east-metro area, known as Capitol Medical Specialty Network. These ventures hope to contract to provide referral specialty care to other primary care-based physician networks, to PHOs, and to health plans.

Hospital acquisitions of medical practices

In addition to hospital efforts to tie medical staff members to their institutions through the formation of physician-hospital organizations, hospitals are now seeking opportunities to purchase medical practices, particularly those involving primary care physicians. In fact, most primary care practices have offers pending from at least one hospital, and some are considering proposals submitted simultaneously by competing systems.

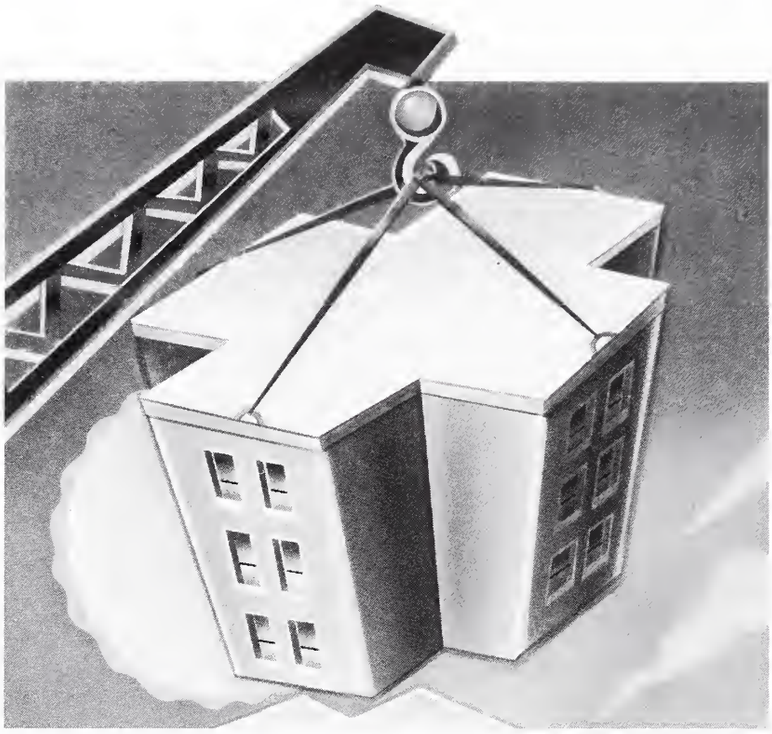
Although it is difficult to estimate the number of physicians in the Twin Cities who are employed directly by hospitals or hospital-related organizations, it is fair to say that the number is sizable and growing. HealthSpan, for example, recently announced its acquisition of Comprehensive Medical Care, a 54-physician medical group in the northern suburbs, and is reported to now employ more than 300 physicians. And HealthEast, with its recent agreement to acquire Metro Family Physicians, P.A., involving more than 20 family physicians, will likely employ more than 60 physicians. Fairview, Methodist, and North Memorial have all acquired medical practices and, as an extension of this activity, provide a range of practice management services to physicians affiliated with their hospitals.

For senior physicians, the possibility of realizing substantial value for their ownership interest in a medical practice can be appealing. For younger physician owners, the sale of a practice is frequently tied to employment contracts with attractive salary guarantees, the lure of deferred compensation, and the prospect of practicing medicine free from administrative and business burdens.

Health Reform Initiatives

Health reform initiatives at both the federal and state level have already prompted many changes in Minnesota. Whether the Clinton administration's health reform proposals will be enacted into law is anything but clear, but generally, its vision seems consistent with the reform initiatives enacted by the Minnesota Legislature in 1992.

In addition to focusing on insurance industry reforms that are intended to improve access to insurance coverage by smaller employers, MinnesotaCare calls for the creation of ISNs throughout the state beginning in July 1994. ISNs have been referred to by some as "super HMOs" that will be responsible for "arranging for or delivering a full array of health care services ... to a defined population for a fixed price from a purchaser."



MinnesotaCare also calls for the gradual introduction of a "regulated all-payer option" (RAPO) beginning in July 1994. (The Minnesota Department of Health has recommended the implementation of ISNs be postponed until July 1996 and the all-payer option until 1997.)This option will allow for administration of benefits and payment of a uniform fee schedule for all payers and providers not part of an ISN system. Depending on how payment levels and regulatory oversight rules are developed, incentives will be created for physician participation in the ISN system.

All health care rendered in Minnesota will be subject to a system of revenue and/or expenditure limits, applicable to HMOs, insurance companies, ISNs, and all providers, based on such benchmarks as "revenue per patient per year" or, if necessary, fee schedule limitations. The revenue limit for calendar year 1994 has been set at 9.4 percent and will be reduced by a statutory formula over the next five years.

The Minnesota Department of Health has circulated a second draft of proposed regulations for implementing MinnesotaCare. These regulations will likely be subject to further change, and it is uncertain whether the additional legislation necessary to implement key portions of MinnesotaCare can be adopted by the Legislature in 1994. Nevertheless, in anticipation of health reform legislation, health care organizations throughout the state already are adopting modifications to their structures and strategic plans to function in an ISN environment. The development of new, powerful health care partnerships involving health plans and provider organizations is discussed above. These vertically and horizontally integrated systems bring together health care delivery systems and payer organizations through joint venture structures or outright consolidation. These organizations will have the provider capacity, management structure, and financial reserves sufficient to function as ISNs under the new legislation.

The changes underway are evolutionary, not revolutionary. The proposed ISN system is being built upon the existing platform of managed care in Minnesota. It is from this foundation that the next generation of managed care organizations will emerge in Minnesota. Blue Cross-Blue Shield, Medica, and HealthPartners are all working quickly to develop their ISN strategies.

Independent physicians in the Twin Cities not directly employed by one of the emerging ISNs will need to affiliate with highly integrated health care delivery systems that have the ability to contract with ISNs, or form their own ISNs, to provide care to those who choose to get care through these networks.

The Bottom Line

These recent market-driven developments create an increasingly clear picture of the new health care delivery systems emerging in the Twin Cities. These organizations are capable of the following:

- providing excellent access to health care services through geographically dispersed offices and facilities;
- offering an integrated system of care that emphasizes continuity and coordination between various health care providers, including nonphysician health care professionals;
- managing the totality of care required by enrolled populations, with particular emphasis on primary care services and coordination between inpatient and outpatient care; and
- objectively documenting continuous improvement in health care service delivery and outcomes.

The Need for Independent Practices to Reorganize

The changing marketplace presents physicians with an exciting opportunity to improve the quality and cost-effectiveness of health care. It is no longer business as usual. Physicians hoping to have continued access to patients in this highly competitive medical marketplace need to consider reorganizing their practices into integrated physician networks that are capable of the following:

• developing new medical service delivery products that are competitive and responsive to the changing requirements and opportunities of the marketplace;

• negotiating and managing risk relationships with managed care organizations;

• enhancing the management and functioning of affiliated practices; and

• utilizing data and other tools to seek improvements in health care service delivery and outcomes.

Physicians need not be employed by organizations such as a hospital or a health plan to achieve these goals. They also need not merge their assets with other practices. Rather, physicians, by coming together in professionally and economically integrated structures, can position themselves to negotiate jointly with group purchasers of health care services while retaining substantial discretion and control over their daily operations.

Physicians desiring to survive and thrive in an increasingly competitive health care environment will need new skills, organizational structures, and management systems. This will likely require establishing partnerships with payer organizations and others that build on the respective strengths and assets of each participant in these new ventures. MM

Douglas Shaw previously served as chief executive officer of the Minnesota Medical Association and currently is president of a Twin Cities-based health care consulting firm.

Thomas Hoban is chief executive officer of the Hennepin County Medical Society.

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RAMSEY

Firearm Mortality in Minnesota

The MMA's Firearm Injury Prevention Task Force reports findings from its investigation into firearm mortality trends in Minnesota.

Minnesota Medical Association Firearm Injury Prevention Task Force

Public concern about violence is growing throughout the country.[1,2] Society is increasingly recognizing the broad impact firearm violence has on practitioners, emergency rooms, hospitals, children, disadvantaged populations, and society in general, leading policymakers and the health care and public health communities in Minnesota to place special emphasis on reducing violence in the state.[3,4]

The Young Physicians Section of the Minnesota Medical Association submitted a resolution on firearm regulation (see sidebar, page 24) to the MMA House of Delegates in 1990, which the House referred to the Public Health and Preventive Medicine Committee. The committee appointed a Firearm Injury Prevention Task Force to study firearm injury and mortality in Minnesota and review the resolution in light of the available information on firearm injuries in Minnesota. Because firearm violence raises heated debate and generates opposing political opinions regarding gun availability and control, the task force at its inception chose to take a neutral stand on gun control and to focus its efforts on the compilation of epidemiological data for use in developing policy intervention strategies. The purpose of this report is to describe the findings of the task force's investigation of firearm injuries in Minnesota and to recount the subsequent actions taken in light of its study.

Methods

Minnesota resident vital record death certificate data from the years 1980 to 1988 were the primary source of firearm injury information the task force used. Mortality data, although accounting only for the most extreme portion of firearm injuries, were viewed as more accurate and complete and were seen as sufficient for the task force's policy-related purposes. The task force obtained additional information on assault rifles in Minnesota from Chief John Laux of the Minneapolis Police Department (personal communication).

Firearm fatalities vary by gender, age, race, and geographic region. We calculated fatality rates for type (suicide, homicide, and unintentional), for age, and for gender groups. We did not calculate rates for ethnic groups.

As part of this investigation, the task force also reviewed federal and state statutes, regulations, and definitions regarding gun ownership, waiting periods, and assault weapons. Further, the task force reviewed the recent scientific and policy literature regarding gun control.

Results

Violent deaths are traditionally classified as unintentional, suicide, and homicide. When all categories of deaths due to firearms are aggregated, firearm-related death ranks among the top 10 causes of death in many states and has been repeatedly identified as a leading cause of death in the United States.[1,2,5-8] Although unintentional firearm fatality rates have decreased steadily since 1900, total firearm fatalities still ranked as the eighth leading cause of death in 1988.[1] Annual U.S. firearm homicide fatality rates have increased since the 1950s; suicide rates due to firearms have been increasing since the 1940s.

During the time period we examined, approximately 300 Minnesota residents died from firearms per year, including about four children aged 0 to 14 per year, almost all of whom were male. The most recent data studied indicate that firearm fatalities accounted for more than 15 percent of all injury fatalities in Minnesota. Less than 1 percent of unintended injury fatalities were due to firearms, while slightly less than one-half of all suicides and homicides resulted from firearms. Slightly more than three-fourths of firearm-related deaths were suicides, and about 16 percent were homicides.

Firearm fatalities by gender

Figure 1 displays the distribution of firearm fatalities by gender and type of fatality. The majority of the fatalities during the nine-year period were male suicides (70 percent), with male homicides (12 percent) and female suicides (7 percent) representing the next largest groups. An examination of gender-specific fatality rates revealed that 10.05 firearm fatalities were due to suicides and

1.73 to homicides per 100,000 population for males, compared with 0.9 firearm-related suicides and 0.51 homicides per 100,000 population for females.

Firearm fatalities by age

Firearm fatality rates by age group and type are presented in Figure 2. For the 10- to 14-year-old group, unintended firearm fatality rates exceeded rates from other causes of firearm death; unintended fatalities represented nearly 45 percent of all firearm deaths in this age group. In each of the older age groups, a similar pattern of rates was observed. Firearm-related suicide rates by far surpassed the rates of other types of firearm mortality, with firearm deaths from homicide being the next highest rate.

Because of the special interest in gun safety for children, the task force examined unintentional deaths by firearms to children aged 0 to 14. From 1980 to 1989, 34 accidental firearm deaths were recorded in Minnesota for this age group; 27 of the children were 10 to 14 years old. All but one were boys. The type of firearm was not specified in the majority of these unintended firearm fatalities.

Trends

An examination of annual firearm fatality rates by gender, age group, and type did not reveal any appreciable trends. Instead, the rates of firearm fatality within population subgroups remained fairly constant over the last decade in Minnesota. Although not considered in the task force's report, a more recent review of Minnesota firearm fatality data from 1991 suggests that the patterns of firearm fatalities observed from the 1980s data have not changed.

Firearm type

Based on information provided by the Minneapolis Police Department, nine of the 2,200 firearms received in the police property room from April 1, 1987, to April 1, 1989, were considered assault weapons. All nine were semi-automatic; none was fully automatic.

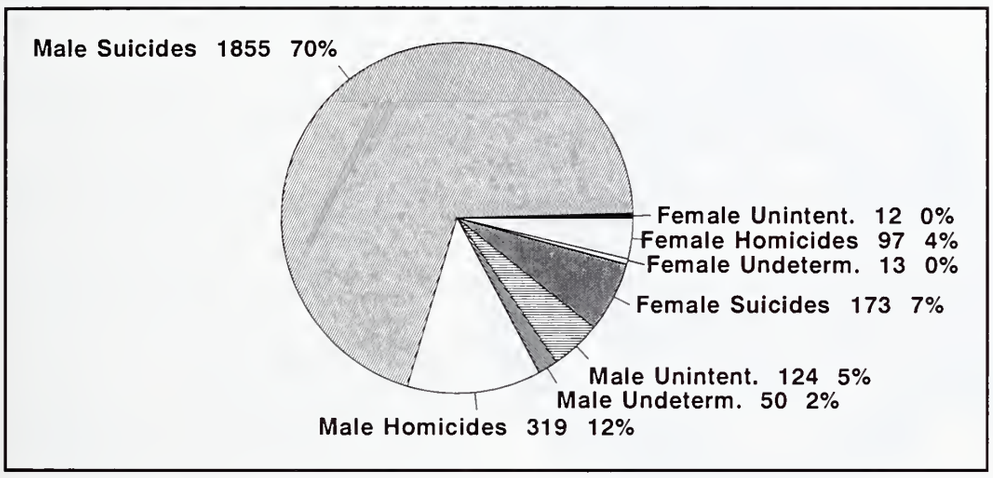

Figure 1—1980 to 1988 Minnesota firearm fatalities by gender and type of fatality. Number and percent of total fatalities.

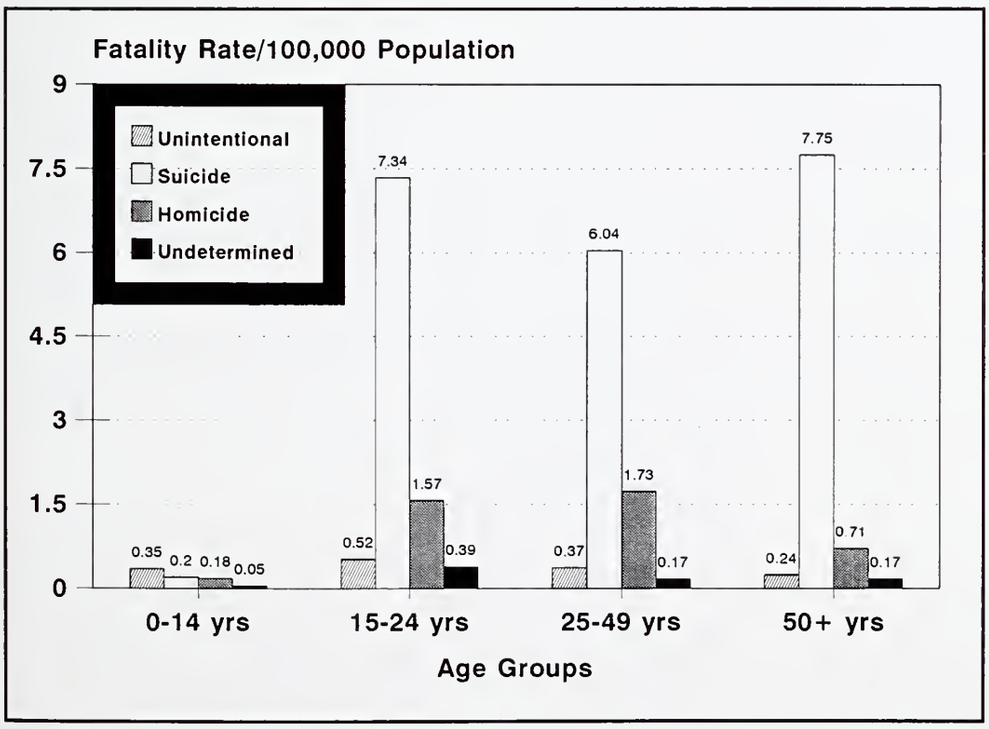

Figure 2—1980 to 1988 Minnesota firearm fatality rates by age and type of fatality.

Discussion

The task force's findings revealed a persistent level of firearm fatality in Minnesota during the last decade. While the majority of these firearm deaths were due to suicides in adult males, Minnesota's children were also among the victims of both unintentional and intentional firearm-related violence. The task force noted that Minnesota currently has a seven-day waiting period, with an accompanying background check, for the purchase of handguns. In terms of firearm type, the task force did not find data indicating that assault weapons have become a major contributor to firearm deaths in Minnesota, although limited information is available to explore this topic fully. The task force also notes that younger adolescents are required to obtain a Firearm Safety Certificate before purchasing a license that allows them to hunt with a parent or guardian.

While the task force findings do not reveal a " firearm fatality epidemic" in Minnesota, they do indicate that an appreciable proportion of injury deaths are related to firearm use and that the level of firearm mortality rates have not changed in the last decade. The results of the investigation highlighted

the complexities involved in developing effective strategies to reduce firearm violence. The marked differences in firearm fatality rates by age, gender, and type suggest that sev-eral factors underlie the current level of firearm fatalities in Minnesota and must be considered in developing programs and policies to reduce violence-related mortality.

Based on the results of the task force's study, in 1992 the MMA Board of Trustees supported the recommendation that the MMA "focus it resources on the prevention of firearm accidents involving children and adults and view firearms and violence as public health issues which require physicians to be involved in an educational effort for the prevention of firearm injuries." Later that year, the MMA House of Delegates adopted a resolution that recognized firearm injuries as a medical problem and promoted a program of education for physicians and their patients aimed at reducing the risk of injury and death from firearm use (see sidebar below). In 1993, the MMA supported, and the Minnesota Legislature enacted, several anti-violence measures intended to reduce firearm-related injuries.[8] These new laws include measures pertaining to assault weapons and to the possession of firearms by minors in school. MM

MMA Firearm Injury Prevention Task Force

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Minnesota Medical Association Resolutions on Firearms

This resolution, submitted to the Minnesota Medical Association House of Delegates in 1990, was referred to the Public Health and Preventive Medicine Committee:

"Be it resolved that the Minnesota Medical Association adopt as policy and support legislation to require a 15-day waiting period for the purchase of all firearms; support a ban on the sale, possession, or transfer of assault weapons* to private citizens; support strong penalties for crimes committed with firearms; and support the development of gun safety programs for children."

* Definition of assault weapon: Any semi-automatic weapon that accepts detachable magazines with the capacity of 10 rounds or more and semi-automatic shotguns with a barrel of less than 19 inches and a folding stock or magazine capacity of more than six rounds.

The MMA House of Delegates adopted this resolution in 1992:

"Be it resolved that the Minnesota Medical Association regard firearm-related deaths and injuries as a medical problem, and be it further resolved that the MMA utilize the report of the Firearms Injury Task Force and develop a process for its member physicians to examine closely the benefits and risks of handgun and assault weapon derived semi-automatic firearms ownership; and be it further resolved that the MMA utilize the report of the Firearm Injury Prevention Task Force and promote a program to educate fellow physicians and their patients regarding the ownership of handguns and assault weapon derived semi-automatic firearms and the concurrent risk of accidents, injury, and death; and be it further resolved that the MMA seek legislative action to require a locking mechanism, such as a trigger guard, to be sold with each firearm purchased."

Going After Guns

Stricter handgun control will not rid our society of violence, but it will save lives and money.

Douglas D. Brunette, M.D.

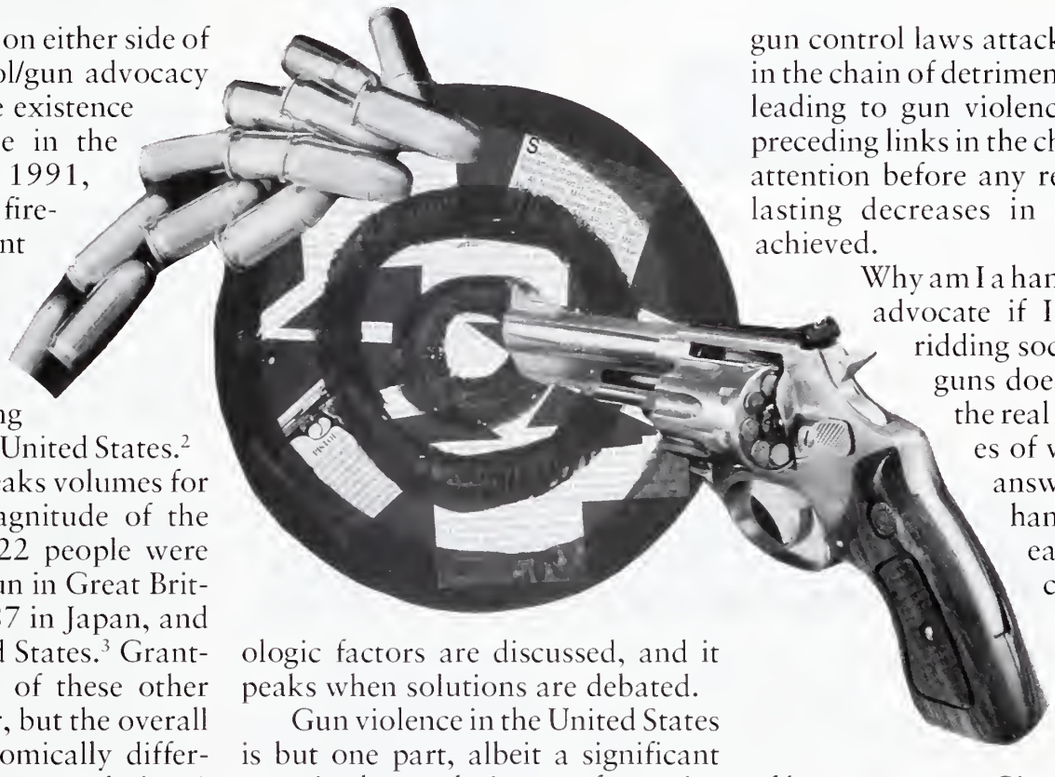

ILLUSTRATION BY KRISTINE BELCAMINO

Few individuals on either side of the gun control/gun advocacy issue argue the existence of growing violence in the United States. In 1991, 38,317 people died a firearm death, 48 percent of which were suicides, 46 percent homicides, and 4 percent accidents.[1] Firearms are a leading cause of death in the United States.[2] A simple statistic speaks volumes for the comparative magnitude of the problem. In 1990, 22 people were murdered by handgun in Great Britain, 68 in Canada, 87 in Japan, and 10,567 in the United States.[3] Granted, the populations of these other countries are smaller, but the overall rates remain astronomically different after adjusting for population.* Handguns accounted for 55 percent of all U.S. homicides in 1992 and were involved in 81 percent of all gun-related homicides.[4] It is hard to deny the existence of a handgun-related violence problem in the United States. The argument between gun control advocates and gun advocates quickly escalates, however, when etiologic factors are discussed, and it peaks when solutions are debated.

Gun violence in the United States is but one part, albeit a significant part, in the total picture of our violent society. As an emergency medicine physician working in an inner-city county hospital, I can attest that people use many other instruments to carry out violent acts—fists, feet, knives, clubs, cars, poisons, etc. Gun control will not rid our society of this propensity for violence. The root causes of violent acts are multifactorial and include poverty; loss of self-esteem; fatherless families; illicit drug trafficking; gun violence depicted in television, movies, and music; and a decline in moral values.

Just as the causes of gun violence are multifactorial, so must be the solutions. There is no one answer. All contributing factors must be addressed individually. Stricter handgun control laws attack the last link in the chain of detrimental life events leading to gun violence. All of the preceding links in the chain will need attention before any real and long-lasting decreases in violence are achieved.

Why am I a handgun control advocate if I believe that ridding society of handguns does not address the real societal causes of violence? The answer is simple: handguns are too easy and efficient a method with which to manifest our violent tendencies. It's a matter of human nature. Given the "right" set of emotionally charged circumstances, most human beings are capable of pulling the trigger in a split second of bad judgment. Given the "right" set of childhood and adolescent experiences, we all would be capable of exhibiting the kind of violent handgun behavior that happens every day in our society.

Will strict handgun control laws make a difference? Most homicides are crimes of passion inflicted on family and acquaintances. The ready availability of handguns increases the likelihood of both intentional and accidental injury. Epidemiologic data support the relationship between firearm availability and increased firearm homicide and suicide rates.[5,6]

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* For example, the population of the United States is about twice that of Japan, but the number of handgun murders in the United States (10,567 in 1990) is well over twice the number of handgun murders in Japan (87 in 1990). The 1990 population of the United States was 249 million; Japan, 124 million; Canada, 27 million; and Great Britain, 54 million.

The corollary is that strict handgun control laws will result in decreasing handgun violence. In the District of Columbia, an abrupt 25 percent decline in homicides and suicides by firearm occurred after stricter handgun licensing laws took effect.[7] A study comparing the firearm homicide and suicide rates of two sister cities again demonstrated the inverse relationship between strict gun control and homicides by firearm.[8] Seattle, Washington, a city with minimal restrictions on gun purchases, had a homicide rate 65 percent higher than Vancouver, British Columbia, a city with strict gun control regulations. The rate for handgun-related homicides was close to five times higher in Seattle, despite the cities' comparable social and economic conditions, as well as equal rates of law enforcement, burglary, robbery, and simple and aggravated assault.

What is the most common reason people in the United States own handguns? "Protection" is the reason I hear most often; a handgun in the house offers a secure feeling, an ability to protect what is most important—self, family, and possessions. The sad fact is that this feeling of security is an illusion. In a study examining the circumstances surrounding 398 firearm deaths occurring in gun owners' homes over a six-year period, nine of the deaths were justifiable self-defense (2.3 percent), 12 were accidental (3 percent), 41 homicide (10.3 percent), and 333 were suicides (83.6 percent).[9] The probability of using a gun to kill oneself or a friend or relative was far greater than the incidence of killing someone in self-defense.

There are other reasons for curbing gun-related violence. The financial costs to society are staggering. In 1985, the total national cost for firearm-related injury was estimated at $14.4 billion.[10] One study, conducted at San Francisco General Hospital, found 86 percent of hospital costs from firearm injuries were paid by taxes.[11] The costs in our own backyard are also significant. In 1992, 165 patients with gunshot wounds were admitted to Hennepin County Medical Center. Charges totaled more than $2.5 million, with an average charge of $15,390 per patient and a collection rate of 46 percent. A total of 65 percent of these collections came from some combination of Medicaid, General Assistance, Medicare, Metropolitan Health Plan, and self pay. These charges do not include physician fees, rehabilitation costs, follow-up visits, long-term care, legal fees, and lost work time. With health system reform a prominent national political issue, significant handgun control legislation seems an appropriate method of preventive medicine and health care cost control.

> "Handguns are too easy and efficient a method with which to manifest our violent tendencies."

I commend the authors of the firearm fatality study that appears in this issue of *Minnesota Medicine* (page 22). More epidemiologic studies analyzing the Minnesota experience with gun violence are needed. The current study, reported by the Minnesota Medical Association's Firearm Injury Prevention Task Force, indicates there is not a "firearm fatality epidemic" in Minnesota. The authors found that the number of statewide firearm deaths remained constant between the years 1980 and 1988. Although the number of deaths statewide may have been constant, the number of firearm injuries at HCMC has increased dramatically. In 1982, 71 patients were admitted to HCMC after suffering a gunshot wound. In 1992, 165 were admitted—a 132 percent increase. The apparent discrepancy between the constant number of statewide deaths from 1980 to 1988 reported in the current study and the dramatic increase in the number of gun-related admissions to HCMC may be related to significant improvements in our trauma system. Although more people are being shot, the number of deaths remains constant as a result of improvements in trauma care. The number of firearm fatalities in Minnesota in 1991 and 1992 were 351 and 356, respectively. This is a significant increase over the average of 300 per year between 1980 and 1988 reported in the task force study. Researchers have estimated that the number of firearm injuries is seven times the number of fatalities.[10] The increase of 50 firearm deaths for the past two years in Minnesota over the 300 per year reported in the task force's study could represent as many as 350 additional non-fatal firearm injuries per year! This agrees with my own anecdotal experience over the past 12 years at HCMC; gun-related violence is markedly increased. I believe Minnesota has a significant handgun-related violence problem that is increasing in magnitude.

A recent poll showed that 80 percent of Minnesotans favor tougher handgun laws for Minneapolis and St. Paul.[12] State legislators should follow their constituents and enact tough handgun control legislation. I would encourage the medical community, and physicians in particular, to examine the facts of gun-related violence on local, state, and national levels. Physicians should determine for themselves the risk-benefit ratio for handgun possession by the general public. If, after careful review, physicians decide the risk outweighs the benefit, I urge support of gun-control legislation. MM

Douglas Brunette is an emergency medicine physician at Hennepin County Medical Center in Minneapolis and residency director for the Department of Emergency Medicine Residency Program.

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Treatment Options for Infertile Couples

Randle S. Corfman, M.D., Ph.D., and G. David Ball, Ph.D.

ABSTRACT

Fast-developing technologies in infertility treatment make it a prime subject for review. In this paper, we revisit some of the basic biology of the male and female reproductive systems and point out where these systems break down. We then discuss some of the many technical treatment options available for the infertile couple and indicate where and when these technologies are best applied.

Picture yourself and your spouse as one of many infertile couples. You feel isolated (even though one of six couples suffers from infertility), angry (why should you be denied a baby when it seems so easy for other couples?), and anxious (the biological clock is ticking, you know). Further, you are just becoming established professionally and money is tight (your health insurance greatly restricts coverage of infertility treatments).

The incidence of infertility is increasing as more and more couples delay childbearing and as sexually transmitted diseases become more common, ravaging both the male and female reproductive tracts. Fortunately, society is also experiencing a heightened awareness of infertility and an accompanying explosion of technology that has made infertility treatments more available throughout the country.

Reproductive Biology Revisited

For a viable pregnancy to occur, many things must go right. Of the approximately 200 million sperm placed in the vagina, only a small fraction make it into the distal portion of the fallopian tube, where they will bind to and fertilize the oocyte. The oocytes of the fetal ovary are arrested in prophase I of meiosis until ovulation, when a single oocyte is released from the ovary and picked up by the delicate fimbria of the fallopian tube by a method that is not clearly understood. The sperm binds to receptors on the oocyte, burrows into the zona pellucida, and fuses with the oocyte plasma membrane. The resulting zygote cleaves repeatedly while the developing embryo is compacted, nurtured, and transported by the ciliated cells that surround it within the fallopian tube. After two to three days, the embryo arrives within the endometrial cavity, where it must hatch from the "shell" of the zona pellucida. Communications via growth factors and other agents then occur between the embryo and the endometrium, implantation occurs, and placentation proceeds. Human chorionic gonadotropin (BhCG) is produced (a chemical pregnancy), and after a few weeks, transvaginal ultrasonography reveals a gestational sac (a clinical pregnancy), and, if all goes well, a baby is born approximately 40 weeks following the onset of the mother's last menstrual period.

When Things Go Awry

As indicated earlier, approximately 15% of couples trying to conceive a child will have difficulty doing so. Because the reproduction process is so complex, many things can go wrong and can involve any reproduction-related system in the man, the woman, or both. Therefore, the evaluation and treatment plan must include both partners. The "couples approach" to infertility provides not only clearer insight into the clinical picture, but also enhances communication with the patients during these emotionally tough times. An overview of major causes and treatments of infertility follows.

Male Infertility

Although half of infertile couples have a male-factor component, physicians frequently overlook the man as a potential contributor to infertility. To assess the man's fertility, the physician takes the patient's history, conducts a physical examination, and analyzes semen samples. If these samples are repeatedly abnormal, the physician looks for and treats any

systemic problems like thyroid disease, pituitary conditions, or varicocele. If infertility persists after correction of a systemic illness, the physician may recommend intrauterine insemination—a sort of numbers game that may enhance the transport of sperm into the female reproductive tract and thereby increase the likelihood of sperm-egg interaction. Intrauterine insemination may be performed in concert with ovarian superovulation by which the female is stimulated with oral and/or injectable medications to release more fertilizable oocytes.

In vitro fertilization can also be used to treat male-factor infertility. When the male factor component of infertility is mild, successful fertilization can often be achieved by simply increasing the sperm concentration during sperm-egg coincubation. More severe cases, however, may require micromanipulation. Techniques that involve a new microsurgery concept can be used to manipulate oocytes—an amazing feat considering that at least 12 oocytes can fit on the period at the end of this sentence. The techniques include subzonal insertion (several sperm placed into the space between the zona pellucida and plasma membrane) and intracytoplasmic sperm injection (direct injection of sperm into oocyte cytoplasm). Micromanipulation has only about a 10% success rate per attempt and costs at least $10,000, but it may be the only option for couples who do not want to use donor semen.

Infertile couples faced with markedly abnormal semen production or the high cost and low success rate of assisted reproductive technologies may choose to use donor semen from an accredited semen bank. This option results in pregnancy rates of 18% to 20% per cycle at a cost of about $250 per cycle.

Clearly, choosing a treatment may be difficult, and the choice may have a dramatic impact on the couple financially, physically, and emotionally.

Female Infertility

Ovarian dysfunction is a common cause of infertility, with etiologies including hypothalamic hypogonadism (anorexia nervosa), chronic anovulation, and ovarian failure. As in the man, thyroid, pituitary, and adrenal disease can affect female fertility.

Treatment can include correcting the underlying condition or enhancing ovulation through oral or injectable medication. Fortunately, the use of laparotomy for ovarian wedge resection has been replaced with medical therapy and laparoscopic treatment. Laparoscopic adhesiolysis can also be used to restore sound relationships between the ovary and the fallopian tube.

For patients who cannot be treated by these means, assisted reproductive technologies (ART) are an option. Transvaginal ultrasound-guided oocyte retrieval is used to non-operatively obtain oocytes from the ovary for use with either in vitro fertilization-uterine embryo transfer (IVF-UET), IVF-zygote intrafallopian transfer (IVF-ZIFT), or gamete intrafallopian transfer (GIFT). These technologies permit use of donor oocytes for women who fail to respond to the therapies described above or who suffer from impending or frank ovarian failure.

Cervical factor infertility

With cervical factor infertility, transport of sperm from the vagina into the uterine cavity is impeded. While totally reliable means of testing are lacking, post-coital testing and testing for antisperm antibodies provide some insight. Treatment options may include simple intrauterine inseminations or ART. With the latter, specifically for cases of severe stenosis of the cervix, GIFT or IVF-ZIFT may be the best option.

Uterine factor infertility

Uterine factor is diagnosed primarily by hysterosalpingography (HSG), hysteroscopy, and, more recently, by ultrasonography. The diagnosis of a luteal-phase defect, whereby the endometrium is improperly prepared for implantation, is made primarily by repeated endometrial biopsies. Treatment of endometrial polyps is primarily by hysteroscopy/D & C, while resection of uterine fibroids is by hysteroscopy and, in rare cases, by laparoscopic or abdominal myomectomy. In the worst-case scenario (a post-hysterectomy patient, for example), use of a gestational carrier or a surrogate is possible via ART. However, the legal ramifications of these two procedures have not been addressed in Minnesota statutes.

Tubal factor infertility

Tubal factor infertility is commonly seen and ranges from intrinsic disease (destruction of the tubal mucosa) to extrinsic disease (perturbation of ovum pick-up mechanism). Tubal factor infertility is currently diagnosed primarily by HSG and laparoscopy. This diagnostic technique is limited by low sensitivity and insufficient access to the fallopian tube lumen. A new technique under development, termed falloposcopy, allows a small fiberoptic to be delivered transcervically via a linear everting catheter, affording exceptional visual inspection of the fallopian tube lumen.[1,2]

Microsurgery to treat distal fallopian tube disease has been largely replaced by laparoscopic surgery, each with pregnancy rates ranging from 20% to 40% over 18 to 24 months following surgery. Proximal obstruction treatment, traditionally by microsurgical resection and anastomosis, has been replaced largely by transcervical tubal canalization. This technique, which is effective in relieving obstruction in more than 80% of cases, is performed on an outpatient basis and preserves microsurgery or IVF-UET as alternatives.[3]

IVF-UET is emerging as the method of treatment for most forms of tubal factor infertility. This treatment permits bypassing of the fallopian tube and obviates the need for surgery.

Immunologic infertility

Immunologic infertility is manifest when either the male or female becomes immunized against sperm, a condition that is treated either by bypassing the cervical mucosa with IUI or by IVF-UET.

The Final Common Pathway: ART

Assisted reproductive technologies, as discussed above, represent a viable alternative for virtually all causes of infertility. The ART process is as follows: The infertile couple is evaluated and prepared for ART after a thorough review of all reproductive systems. The woman then undergoes controlled ovarian stimulation to increase the number of oocytes available for fertilization. Transvaginal ultrasound-guided oocyte retrieval, an outpatient procedure, is done under intravenous sedation. For GIFT, the oocytes are mixed with sperm and returned to the fallopian tube by laparoscopy (this usually requires a general anesthetic). If in vitro fertilization is used, the transfer of developing embryos can occur the following day at laparoscopy (IVF-ZIFT) or by transcervical transfer two to three days later (IVF-UET).

A BhCG is obtained approximately two weeks after oocyte retrieval (to determine whether a chemical pregnancy has been established), and if rising levels are seen, a transvaginal ultrasound examination is performed approximately four weeks after retrieval to document a gestational sac (a clinical pregnancy). A delivery should occur approximately 34 weeks later. The risk of spontaneous abortion is approximately 25% following chemical pregnancy documentation, with two-thirds of these occurring before a clinical pregnancy is documented.

The Society of the Assisted Reproductive Technologies (SART), a special interest group of the American Fertility Society, requires its members to report their auditable results yearly. The national average for clinical pregnancy rate per retrieval is 19.1%, with a delivery rate of 15.2%.[4] It is important to note, however, that this is the national average. It is not uncommon to find centers with pregnancy rates at close to twice the national average. Patients, as well as referring physicians, are encouraged to research potential programs.

The importance of age and success with ART cannot be overemphasized. As shown in Figure 1, we have found that pregnancy rates for women under age 35 are markedly higher than for those 35 or older. The decreased pregnancy rate that accompanies increased age is apparently due to two factors. First, fewer eggs are obtained at retrieval, and in turn, fewer embryos are produced. Second, the implantation rate per embryo decreases with increasing age. These data underscore the importance of early referral for ART.

Nonetheless, women near 35 or older have reason to be optimistic. As shown in Figure 2, a new procedure, assisted-zona hatching (AZH), allows a small defect to be created on the zona pellucida, the "shell" surrounding the oocyte that prevents fertilization by more than one sperm. Further, this shell is of major importance in providing compaction of the developing embryo. However, before the embryo can implant in the uterine wall, it must first hatch from the zona pellucida, and this can present an insurmountable barrier to the embryo. It appears that oocytes from women in their late 30s may have a "harder" zona than younger women have. AZH may help overcome this. The technique has proved successful for several of our patients over age 35.

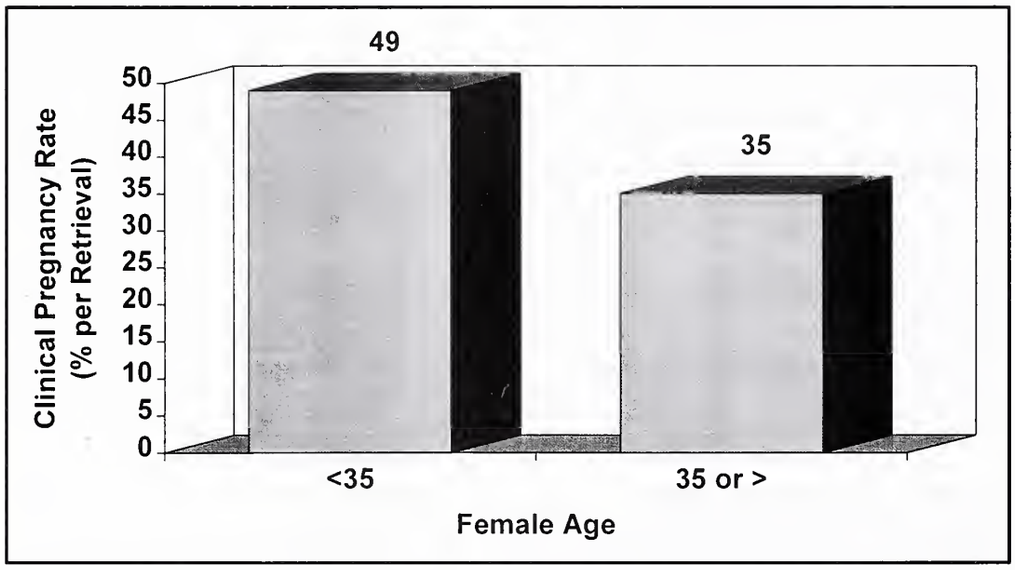

Figure 1—Clinical pregnancy rates per oocyte retrieval from the Midwest Center for Reproductive Health for couples in whom the female's age is less than 35 or is 35 to 42.

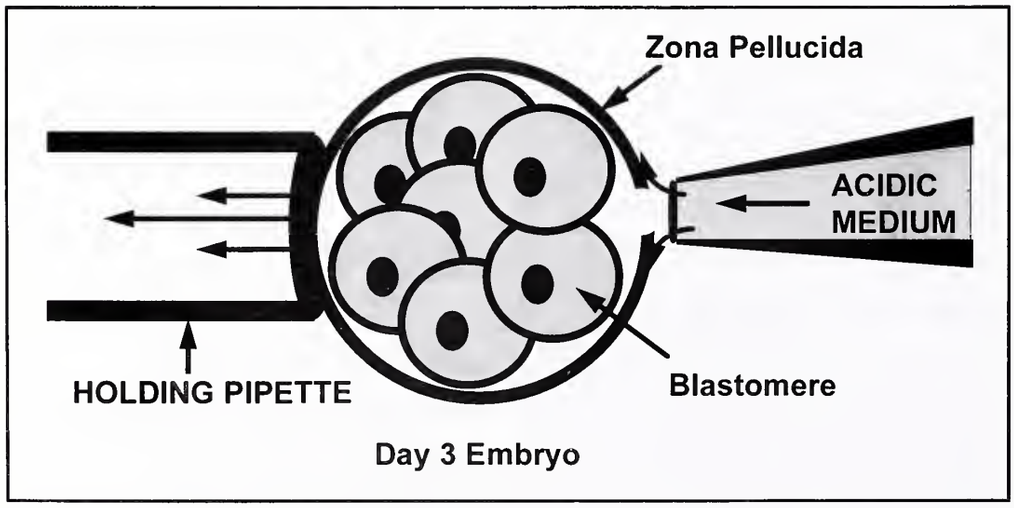

Figure 2—Assisted zona hatching. Micromanipulation is used to create a weakened area on the zona pellucida so as to improve hatching efficiency. A holding pipette applies suction upon the embryo while an acidic solution is used to dissolve a portion of the zona.

IVF for Everyone?

As pregnancy rates with IVF continue to improve, the argument could be made that this modality should be used as the first-line treatment for

infertile couples. This concept was presented by Grainger,[5] who recently performed a cost analysis on a variety of infertility diagnoses, factoring in the cost of diagnosis and treatment leading to a live birth. These results, summarized in the Table, reveal a cost per delivery ranging from $16,000 to $125,000 for conventional infertility treatment. Grainger then predicted a cost per delivery for IVF at delivery rates per retrieval of 18%, 35%, and 50%, as shown in Figure 3. At delivery rates of 35% to 50%, IVF would be the most cost-effective primary means of therapy for most diagnoses. If IVF were adopted as the treatment of choice for most cases, the secondary result would be a lowering of the age at which couples undergo IVF. In turn, that would further contribute to higher success with IVF.

Table

Conventional treatment of infertility: success and cost analysis

Diagnosis	Number of term deliveries/100 patients (24 months)	Cost per delivery
Adhesions	60	$20,833
Hydrosalpinx and adhesions	15	$83,333
Proximal tubal obstruction	45	$27,777
Endometriosis	50	$25,000
Tubal anastomosis	75	$16,666
Male factor infertility	10	$125,000

*Adapted from Grainger [5]

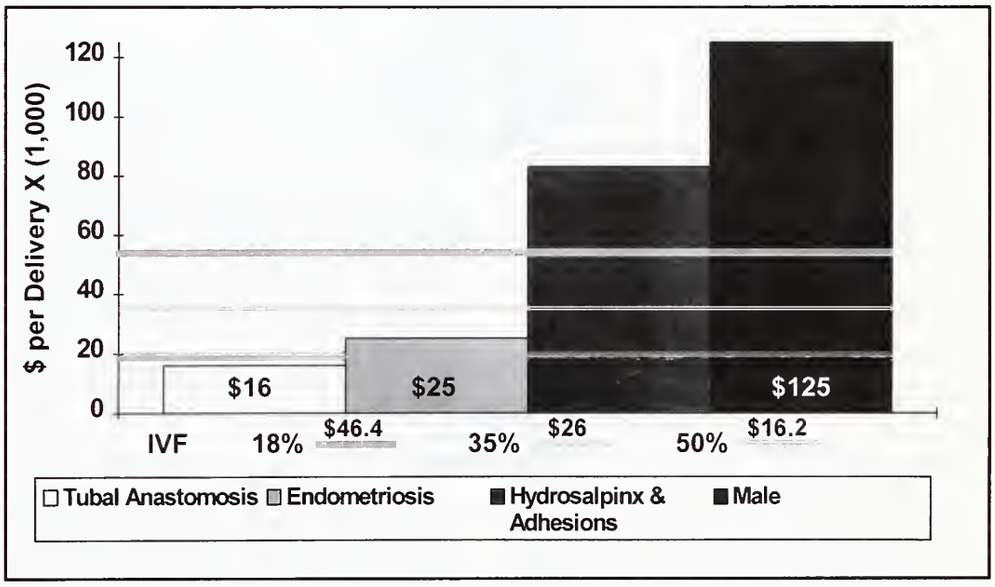

Figure 3—Cost analysis of traditional infertility treatment, by diagnosis. Bars indicate the cost per delivery for common diagnoses. The overlaid lines correspond to the cost per delivery resulting from IVF-UET if the ART center has 18%, 35%, or 50% delivery rates per oocyte retrieval.

Access to ART

In the past, only couples who live in metropolitan areas could benefit from ART, significantly reducing the availability of this technology. We recently demonstrated, however, that a very effective system utilizing satellite clinics in rural areas can be established whereby the patient remains at home until the actual IVF procedures are performed.[6] We found that this approach significantly reduces the overall demands of ART on patients without adversely affecting the chance of success.

Other Choices

Many couples, after weighing their options, choose to adopt or remain childless. Adoption is becoming increasingly difficult as the courts struggle with legal rights of the birth and adoptive parents. Choosing not to have children may represent the best option for many couples, depending on their lifestyles.

The Treatment Dilemma

Although a great number of alternatives are available to infertile couples, financial, ethical, and emotional concerns often limit patients' choices. The high-technology approaches are expensive and often come early in a couple's careers when financial liabilities outweigh assets. As discussed previously, reproductive potential is greatest in earlier years. When a couple's reproductive potential is the greatest, financial assets tend to be the least, thereby precluding use of the more successful technologies. By the time the couple has more income, reproductive potential is the lowest.

Accompanying, and perhaps induced by, these financial stressors are emotional and ethical dilemmas that can exacerbate the stress infertile couples experience. Currently, third-party payers do not reimburse for professional counseling services for these patients, compounding the problems they face.

Summary

A wide variety of options are available to couples who suffer from infertility, ranging from adoption to high technology. Couples contemplating infertility therapy will face numerous emotional, physical, ethical, and financial considerations in arriving at their decision. Given the magnitude of the problem, primary care physicians should be well-versed

in the available options and should encourage patients to seek consultation. Other authors have suggested that physicians who accept patients with infertility bear a heavy responsibility to continue the investigation and therapy only to the limit of their competence, "doing no harm before referring the couple to specialists at the next level."[7] Further, it follows that since the chance of success declines with age, prompt referral is critical."[7] Fortunately, technological advancements continue to improve our patients' chances of conceiving. MM

Randle Corfman is a specialist in endocrinology, fertility, and gynecology at the Midwest Center for Reproductive Health. David Ball is director of the Reproductive Biology Laboratory at the Midwest Center for Reproductive Health and director of the Assisted Reproductive Technology Laboratory at Methodist Hospital.

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The Monitor
News For Minnesota Physicians

Announcements

Minnesotans Win Achievement Awards

Four Minnesotans have won 1994 AMA/Glaxo Achievement Awards. The medical student recipients are Michael Achinger, the University of Minnesota, and Riico Dotson, Mayo Medical School. The resident physician recipients are J. Michael Gonzolez Campoy, M.D., who specializes in internal medicine, and Scott R. Wright, M.D., who specializes in cardiology. The awards were presented February 10.

• • •

Doctors Day Is March 30

Doctors Day 1994 will be celebrated nationwide on March 30. The celebration will honor today's physicians who dedicate their careers to the care of their patients and to the advancement of medical technology. The first observance of Doctors Day was held in 1933 by the Barrow County Auxiliary to honor the achievement of Crawford W. Long, M.D., who in 1842 was the first physician to administer ether anesthesia to a patient before surgery.

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White House Hotline

If you would like to send a message to President Clinton, you may call the White House Comments Office at 202/456-1111, and leave a two-minute recorded message.

Final MDH Report Delays ISNs and RAPO

At the last minute, the Minnesota Department of Health (MDH) is applying the brakes to the fast-moving health system reform effort. The final MDH report and legislative proposal would delay full implementation of integrated service networks (ISNs) and the regulated all-payer option (RAPO) until July 1997. Implementation would begin on the original start-up date of July 1, 1994, but the final steps wouldn't be taken until three years later. This is a major change from the timeline in earlier drafts. Slowing the breakneck speed of implementation is expected to ensure a more orderly transition and avoid disruption of existing health care systems.

By July 1, 1996, "all permanent rules and statutes for the entire restructured health care delivery and financing system must be complete." This would give purchasers, consumers, providers, and health plan companies a full year to plan their transition to the new health care system. ISNs could begin to form as soon as rules are adopted, but the mandatory all-payer option for services provided outside an ISN wouldn't be in effect until 1997.

The department will forward its report and legislative proposal to the Legislative Committee on Health Care Access. It will be up to the legislators to decide whether to introduce the bill as written or modify it. Legislators will also consider the recommendations of the Minnesota Health Care Commission. The commission will submit a report citing areas of relatively minor disagreement with the department's bill and will strongly urge legislators to combine the ISN/RAPO implementation plan with the commission's Universal Coverage Plan and Consumer Incentives Report in a single piece of legislation. "It is critical to link all three reports if we are to achieve health care reform," said Jasper Daube, M.D., the MMA representative on the commission. (See page 35 for the Minnesota Medical Association position on the department's proposal.)

A summary of the MDH report follows.

Implementation Begins July 1, 1994

CISNs

A major new concept appears in this bill—community integrated service networks (CISNs), which would operate under provisional status from 1994 to 1997. A spin-off of the ISN, the CISN is defined as "a formal arrangement licensed by the commissioner ... for providing prepaid health services to enrolled populations of 50,000 or fewer enrollees." At least 51 percent of the members of the CISN governing body would have to live in its service area. CISNs would operate under current HMO law but would be exempt from a number of HMO requirements and would be allowed greater flexibility. They would have to demonstrate net worth of at least $1.5 million, of which $500,000 would have to be in a controlled deposit. To help meet these requirements, the CISNs could

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use a guaranteeing organization. If the CISNs could show they lacked access to sufficient capital, they could use accredited capitated providers to satisfy up to 30 percent of their net worth requirement. CISNs would be licensed beginning July 1, 1994, and could begin providing care on January 1, 1995.

The MDH plans to establish a "shared services cooperative" to offer a number of services to CISNs and ISNs that choose to participate. The cooperative would provide administrative, legal, and technical assistance, as well as billing and provider contracting services.

The creation of CISNs responds to comments by the MMA and others that earlier drafts did not allow enough flexibility for small ISNs to develop in their local communities.

Accountability

Beginning July 1, 1994, measures take effect that would increase public accountability for all existing health plan companies, including HMOs, Blue Cross and Blue Shield of Minnesota, and indemnity insurers. Health plan companies would be required to submit annual action plans that include the following information:

- criteria used to determine provider eligibility;
- number and type of providers;
- use of allied health professionals;
- policy for serving high-risk groups;
- use of data to improve quality;
- contributions to regional public health goals;
- health coverage options for rural communities.

In addition, by April 1 of each year, all health plans would have to submit "quality indicators" to be included in "report cards" that would be available upon request from the Information Clearinghouse. The report cards would also include the results of surveys on patient satisfaction. Health plan companies would be required to cooperate with efforts to conduct the consumer surveys.

Reinsurance and Risk Adjustment

A Reinsurance and Risk Adjustment Association would be created July 1, 1994, and begin operations January 1, 1995. All health plan companies would have to buy reinsurance for their enrollees, purchasing the same level of reinsurance coverage for each enrollee. This provision is meant to spread the risk of insuring high-risk and special needs individuals. A separate condition-specific reinsurance mechanism could also be developed to reinsure selected high-cost cases.

Uniform Billing Forms and Utilization Review

Standard billing forms would be implemented January 1, 1995. Any insurers that performed utilization review would have to use standard procedures. The MDH would convene an advisory committee to consider ways to standardize utilization review content and would submit recommendations to the 1996 Legislature.

The Transition Continues

Effective July 1, 1995, health plans could not issue any new policies with an annual deductible higher than $1,000. Existing policies with higher deductibles could be renewed. Effective January 1996, all health plan companies would have to cover dental care services for enrollees under 18 years of age.

Full Implementation Is Slated for July 1, 1997

Beginning July 1, 1997, all health insurance companies would have to operate under laws governing ISNs or under laws governing RAPO. Preferred provider organizations could continue to provide care to their existing enrollees without becoming licensed as ISNs through December 31, 1997. After that date, insurers in RAPO could not use provider networks.

Less RAPO Regulation

A dramatic difference between this and earlier MDH drafts is the decreased amount of regulation for RAPO. Previous drafts called for regulations regarding the use of technology, use of mid-level practitioners, data reporting, etc. The new language makes it clear that RAPO is intended to be a legitimate option for purchasers and providers rather than a way to force them into ISNs. The bill states that the purpose of RAPO is "to provide an alternative to integrated service networks for those consumers, providers, third-party payers, and group purchasers who prefer to participate in a fee-for-service system."

Phase-in of RAPO Fee Schedule

The timeline for implementing RAPO calls for use of a standardized billing form in January 1995, introduction of a voluntary fee schedule in July 1996, and a mandatory fee schedule in 1997. Fees would be set by multiplying Medicare RVUs, or relative value units, by a Minnesota-specific conversion factor. The commissioner could create new RVUs through rule-making. The RAPO fee schedule would not apply to services reimbursed under Medicare and state programs.

The language describing the development of the physician fee schedule is improved in the final MDH report. The report makes it clear that the conversion factor would be based upon Minnesota-specific claims data and that it would be set at a level that is "consistent with current relevant health care spending." There would be one volume performance standard (VPS) for the entire state to keep spending within the overall growth limit. Balance billing would be prohibited. The commissioner will submit a report recommending which health care professionals should be paid at the full rate and which should be paid at a fraction of that rate by January 1, 1995. The report will also consider fees for services not covered under the Medicare fee schedule.

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ANNOUNCEMENTS

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MMA SETS PRIORITIES FOR '94 SESSION

The MMA will devote its greatest efforts to the following initiatives:

• Support anti-violence legislation and educate the medical community and the public about violence issues.

• Urge enactment of a broad-based tax and eliminate the 2 percent tax on providers.

• Support the $2 increase in the cigarette tax over the next five years as a way to discourage smoking and to help pay for the expense of tobacco-related disease.

• Encourage implementation of a standard benefit set in 1995 rather than 1997.

• Support rules for ISNs that would ensure access and quality care for all.

• Support rules for RAPO that would make it a viable option for physicians who do not wish to join an ISN.

• Urge enactment of the universal coverage proposal, which includes recommendations for phasing in insurance reform, reducing non-financial barriers to care, implementing a guaranteed medical benefits set, increasing funding for the MinnesotaCare program, and making health insurance mandatory.

MMA Adopts Positions on Legislation

The MMA Executive Committee met February 15 to consider recommendations by the MMA Committee on Legislation, chaired by David Swanson, M.D., and to adopt MMA positions on bills that will come before the Legislature this session.

MMA Supports Department of Health's ISN/RAPO Bill

The MMA supports the Department of Health's final legislative proposal for implementation of integrated service networks (ISNs) and the regulated all-payer option (RAPO). The proposed bill is significantly improved over earlier drafts. It encourages locally controlled networks to develop from the ground up; it reduces the amount of regulation for ISNs and RAPO; it defines RAPO as a viable alternative to the ISNs; it slows the timetable to allow for an orderly transition; and it increases health plan accountability.

The department's ISN/RAPO proposal is, however, just one of three components that must be included in the health system reform bill. The MMA will strongly urge legislators to include the Minnesota Health Care Commission's Universal Coverage Report, calling for insurance reforms and requiring everyone to have health insurance, as well as its Consumer Incentives Report, calling for an increased tobacco tax, increased alcohol tax, tougher seat belt laws, and mandatory helmet laws. The MMA will also urge legislators to enact a broad-based tax to fund universal coverage.

The MMA recommends the following improvements in the department's ISN/RAPO proposal:

• Add language that specifically states that all Minnesotans will have health insurance coverage by July 1, 1995. (This would push up the 1997 starting date in the Minnesota Health Care Commission's universal coverage proposal.)

• Add insurance reforms, including requirements that all Minnesotans must have health insurance; that premiums for a particular health plan must be the same for everyone regardless of their health status or risk; and that people must be allowed to move their insurance between health care companies without restrictions or exclusions.

• Adopt a broad-based tax to subsidize health insurance for low-income Minnesotans.

• Require the commissioner of health to recommend a universal medical benefit set to the Legislature for adoption by October 1, 1995, rather than 1997, and ask the commissioner to consider the report of the MMA's Guaranteed Benefits Task Force as she develops recommendations.

• Allow CISNs to build up their net worth requirements over a two-year period if they demonstrate they don't have access to sufficient capital.

• Delete the RAPO user fee from the bill because it is an inappropriate funding mechanism that will place another tax on the health care system and add to consumers' health care costs.

MMA Supports Malpractice Coverage

The MMA endorses the concept of malpractice insurance coverage, or other proof of indemnification for all practicing health professionals, and believes it should be part of a comprehensive reform proposal based on MICRA-type reforms. These reforms should include limits on non-economic damages, limits on attorney contingency fees based on a sliding-scale proposal, apportionment of damages based on percentage of fault, and equal access to health care providers for both the plaintiff and defense.

Positions continued on page 36

Announcements

Governor Announces Re-appointments to BMP

The governor has reappointed Doris Brooker, M.D., and James Knapp, M.D., to the Minnesota Board of Medical Practice. A notice of the vacancy left by the death of Daniel Gaither, M.D., appeared in the *State Register* February 7.

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Medicare Coding Change

One new Medicare CPT code, 66930, has been added to the list of those requiring preauthorization for use of an assistant at cataract surgery. According to the Foundation for Health Care Evaluation, this CPT code has been identified as a procedure for which an assistant was needed in 100 or fewer cases nationwide. Now preauthorization is required for the following CPT-4 codes: 66852, 66920, 66930, 66940, 66985, and 66986.

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DNR Form Will Soon Be Available

The standard "Do Not Resusitate" (DNR) form, which was approved for use throughout the state by the 1993 MMA House of Delegates, will soon be available. The DNR form gives people the option of limiting their emergency medical care when appropriate. To be valid, the form must be signed by the individual, his or her physician, and a witness. An article about the DNR form, including information on how to obtain it, will appear in the April issue of *Minnesota Medicine*.

Positions *continued from page 35*

MMA Supports Part of DFL Anti-Crime Legislation

The MMA supports provisions in the DFL-Anti-Crime Legislation (H.F. 1822-Skoglund) that would increase the penalties for crimes committed with guns. The MMA supports making drive-by shootings a felony punishable by the maximum sentence and supports a minimum three-year mandatory sentence with no plea bargaining for a gun-related crime.

The MMA takes no position on the gun ownership provisions in the Anti-Crime Legislation. These provisions would raise the age requirement for owning a pistol or semi-automatic military-style weapon from 18 to 21 years of age and would prohibit juveniles who have been convicted of a juvenile crime from possessing these weapons until 10 years after the disposition of their conviction. The bill would also make it a felony to transfer these kinds of weapons to a person under 21 and would make it a felony for anyone under the age of 21 to carry a semi-automatic military-style assault weapon in a public place.

Although it is a high priority for the MMA to support anti-violence legislation, any proposals to put controls on gun ownership cause deep divisions within the association. The MMA Board has asked the MMA Committee on Public Health to study the AMA policy on handgun and automatic repeating weapons and submit a report to the MMA House of Delegates in September 1994. In general, AMA policy favors gun control and calls the "uncontrolled ownership and use of firearms, especially handguns, a serious threat to the public's health." The AMA supports legislation restricting the sale and private ownership of large clip, high-rate-of-fire automatic and semiautomatic firearms.

MMA Supports Ban on Exclusive Contracts

In a reversal of its earlier position, the MMA will support a prohibition on exclusive relationships that has been proposed by Attorney General Hubert Humphrey III. The attorney general has drafted legislation that would prohibit a provider from entering into any contract or subcontract with an ISN or third-party payer on terms that require the provider not to contract with any other ISN or third- party payer. This provision would not apply if the provider is an employee. The commissioner would periodically review contracts among health care providing entities and ISNs to determine compliance with this section. Any provider could submit a contract to the commissioner for review if the provider believed this section had been violated. Any provision of a contract that violated this provision would be null and void and the commissioner could seek civil penalties up to $25,000 for each such contract.

The MMA's change in policy comes in response to fears that pressure is mounting on some physicians to enter into exclusive contracts and that this will limit their freedom. Physicians could still choose to contract with only one ISN, but could not be obliged to do so. • • • • •

MMA Media and Spokesperson Training

The MMA will offer media and spokesperson training Saturday, April 30, 9 a.m. to 1 p.m. The program will include the following topics:

- speech structure
- impromptu speaking
- interview skills
- television interviews
- self-evaluations

The program will be held at the MMA office building, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413. The registration fee is $25. To register, send a check to the Minnesota Medical Association, attention: MarkVukelich. For more information, call Mark Vukelich, 612/378-1875 or 800/999-1875. The program will be limited to the first 15 registrants. • • • • •

LEGISLATIVE NEWS

MMA Stops Radiologic Technician Bill

Last year the MMA opposed a bill (H.F. 908) that would have required anyone who applied ionizing radiation or administered radiopharmaceuticals to be licensed as a radiologic technician. The MMA argued that this legislation could put an economic burden on small, primary care clinics where nurses or lab technicians perform some x-rays. The proposal, introduced by Rep. Darlene Luther, DFL-Brooklyn Park, never received a hearing.

Now, as a result of pressure from the radiologic technicians and their lobbyist, Wy Spano, the bill is back in 1994, and the MMA continues to oppose it.

The proposal has been modified slightly. Instead of seeking licensure and a separate board with regulatory oversight, the radiologic technicians are asking for certification from the Minnesota Department of Health (MDH) and the establishment of a 15-person Radiologic Technology Advisory Council that would report to the commissioner of health. The MDH would be required to develop a professional code of ethics and rules establishing minimum educational and certification requirements, including an examination for certification.

To support the MMA's strong lobbying efforts, many MMA physicians have called their legislators and urged them to oppose this bill. Representing the MMA, Ray Lindeman, M.D., testified against the bill at a preliminary hearing in the House Human Services Finance Division Committee February 16. The committee tabled the bill, and it now seems unlikely the House will take it up again this session.

Coalition Kicks Off Campaign to Support Cigarette Tax

• • • • • The Tobacco Tax Coalition for a Healthy Minnesota, a broad-based group of more than 40 organizations, including the Minnesota Medical Association, held a news conference in St. Paul February 17 to announce support for the Minnesota Health Care Commission's proposal to increase the tax on a pack of cigarettes 40 cents each year for the next five years. The commission's Consumer Incentives Report proposes the tax increase as a way to fund health coverage for the uninsured and preventive health programs.

"Smoking is our No. 1 health care problem," A. Stuart Hanson, M.D., told reporters. "When used as directed, cigarettes kill." He predicted that a higher cigarette tax would cut down on smoking and improve the health of Minnesotans. The Department of Revenue estimates that a 10 percent increase in the cost of tobacco leads to a 4.5 percent drop in consumption. The effect is even more dramatic for children and low-income populations—a 10 percent price increase leads to a 12 percent drop in their consumption.

Increasing the tax has worked in other states and countries. Since California raised its tobacco tax by 25 cents a pack and began preventive health education efforts, smoking has dropped 23.6 percent. Since Canada raised the cigarette tax to $3.25 a pack in 1991, smoking dropped by one-third among adults and two-thirds among teenagers.

"Every patient who needs oxygen to cross the street, or has undergone multiple cardiac surgeries, or suffers the pain associated with lung or head and neck cancers would jump at the chance to rewrite their smoking history, but they can't," said Anne Joseph, M.D., M.P.H., an assistant professor at the Veterans Administration Medical Center and University of Minnesota. "An increase in the tobacco tax would help a generation grow up smoke-free, without a difficult addiction to overcome."

Robert Taylor of the Urban Coalition told the news conference, "Smoking is more prevalent among minorities and low-income people than it is among other socioeconomic groups. As a result, the lung cancer rates are six times higher for blacks than for white people."

Not only will the tax improve Minnesotans' health, but it will also bring down health care costs. "Tobacco costs Minnesota nearly a billion dollars a year in direct health care costs and lost income due to smoking-related disease and premature death," according to Will Manning, Ph.D., an economist and professor in the School of Public Health at the University of Minnesota.

Seventy percent of the money raised by the cigarette tax would be used to fund the MinnesotaCare program and 30 percent to fund smoking prevention programs, the Special Supplemental Food Program for Women, Infants and Children (WIC), screening for Chlamydia, and family planning.

The tax is expected to be a politically hard sell during an election year, but supporters were optimistic. "Will reason win out over economics?" Hanson asked. "That's the test."

MINNESOTACARE NEWS

Commission Considers Technology Distribution

The Minnesota Health Care Commission has reached agreement on the direction the Health Technology Advisory Committee (HTAC) should take in planning the distribution of high-cost technology.

At the recommendation of a subcommittee, chaired by Ray Christensen, M.D, the commission has agreed that HTAC should not regulate or enforce the distribution of technology, but there should be a sanctioned process whereby health plans, purchasers, and providers could voluntarily come together and consider plans for the regional use and distribution of technology. Antitrust protection would be needed for this kind of collaboration. In addition, the task force recommended that it expand its scope and consider "facilities and functions" as well as technology. It would consider such issues as the availability of emergency room services and pediatric services in a particular region.

The task force will continue to develop these concepts and will make recommendations regarding the role HTAC should play in planning the distribution of technology and of "facilities and functions."

The commission had great difficulty reaching consensus on this issue. Commission members' suggestions had ranged from instituting a certificate of need to allowing the market to determine distribution. At the February 2 meeting, consumer representative Virginia Greenman cited "vicious rumors circulating in her community that there would be two trauma centers five minutes apart because of a turf war between competing ISNs." Later, she learned the rumors were false but concerns lingered. Jasper Daube, M.D., the MMA representative, urged commission members not to go any further in the direction of more regulation. He said that when HTAC defines the appropriate use for a particular technology, that information will indicate how it should be distributed. For instance, the determination that t-PA is effective in treating a mild heart attack if it is administered quickly leads to the conclusion that it should be widely available. Objecting to pejorative terms like "medical arms race," Daube reminded commission members that technology saves lives, and he urged them to let ISNs use HTAC information to make their own decisions.

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Commission Withdraws Conditional Guaranteed Issuance Proposal

An actuarial report presented to the Minnesota Health Care Commission February 2 shot down its recommendation that the Legislature require conditional guaranteed issuance by 1995. In its Universal Coverage Report, the commission had recommended that by July 1995 all health plans should be required to issue and renew health coverage for anyone willing to pay the premiums under certain conditions, but the effective date was subject to change based upon actuarial analysis. Unfortunately, Deloitte and Touche found that requiring guaranteed issuance in the absence of universal coverage would raise premiums in the individual insurance market by an average of 54.6 percent. In the light of this finding, the commission voted to withdraw its recommendation.

The commission's recommendations for guaranteed issuance in 1997, along with other major insurance reforms and a requirement that everyone have insurance, still stand. The commission also continues to recommend that beginning in 1995 health plans must allow insured people to move from one plan to another offered by the same company without restrictions or exclusions. The actuarial figures made it clear to commission members that insurance reforms won't work until everyone is required to have insurance. "Insurance reforms have to be implemented in conjunction with mandated universal coverage and a subsidy," said Michael Scandrett, executive director of the commission. Noting the difficulty of persuading legislators to fund the needed subsidies for universal coverage, Tom Swain, chair of the commission, said he expected legislators to "delay the decision on financing until another day when it isn't an election year."

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Study Looks at Potential ISNs

There are already 18 groups in Minnesota positioned to form ISNs, according to a study by the Institute for Health Services Research. The report was commissioned by the Legislature to find out about ISN development. John E. Kralewski, Ph.D., summarized the institute's preliminary findings at the February 2 meeting of the Minnesota Health Care Commission. He said that physicians' "ownership role in creating cost-effective care," is a main feature of the ISNs that are being formed. "The networks are looking at the components of care to see if there's a better way of doing it or if it could be done by different people." He predicted there will be half as many office visits, half as many specialists, and three or four times as many nurse practitioners. The role of nonphysician health care providers will be narrowly defined by the ISNs. Patients will play a more active role in making decisions, possibly through the use of interactive software that will give them information about the pros and cons of medical procedures. The study found that networks are developing flexible arrangements that would allow group practices to be capitated

MINNESOTACARE NEWS

while solo practices could join on a fee-for-service basis and be subject to greater micro-management by the ISN. Kralewski sees little reason for the state to regulate ISNs except for setting solvency requirements and possibly a tax to pay for high-cost technology centralized in a few locations and shared by all ISNs. He will be an enthusiastic advocate for ISNs at the Legislature. "Unquestionably, patients will be better served and quality of care will go up," Kralewski said. He also predicted substantial cost savings under the new system. Contradicting conventional wisdom that says ISNs won't work in greater Minnesota, he said that "a number of organizations in outstate Minnesota have the capacity to form successful ISNs."

Legislative Committee Considers Contracts

Members of the Legislative Committee on Health Care Access disagree on the issue of provider contracting. Rep. Lee Greenfield, DFL-Minneapolis, supports the MDH proposal to allow ISNs to set their own criteria for joining their networks. He believes ISNs must be able to limit their networks in order to be cost-effective and competitive. However, Sen. Linda Berglin, DFL-Minneapolis, would support language that would prevent ISNs from setting criteria that are too restrictive.

PRACTICE GUIDELINES

New HIV Guidelines Proliferate

The American Medical Association has updated its guidelines to help physicians diagnose HIV infection, determine the disease stage, and treat patients during the early stages of infection. "Primary care physicians are concerned with the total treatment of patients," said M. Roy Schwarz, M.D., senior vice president of Medical Education and Science for the AMA. "They are well-suited to manage patients through the progression of HIV infection with the assistance of other specialists and health care providers." The AMA's guidelines have been endorsed by the National Cancer Institute and the Centers for Disease Control and Prevention. You may obtain copies of the guidelines by contacting Lydia Steck at 312/464-5372.

The Public Health Service's Agency for Health Care Policy and Research (AHCPR) has also released guidelines designed to help family physicians, pediatricians, and other "frontline" primary care practitioners provide early care for HIV infection. "A key recommendation is that patients who have not yet developed symptoms be given daily preventive doses of a sulfa drugs shown to prevent Pneumocystis carinii pneumonia, a principal killer of HIV-infected persons," said HHS Assistant Secretary for Health Philip R. Lee, M.D., who heads the Public Health Service. Lee said that using the drug for asymptomatic persons whose CD4 count falls below 200 cells per microliter could help "perhaps thousands of people, extending their lives and preventing debilitating bouts of illness."

The AHCPR's recommendations are almost identical to those of the AMA, according to John Henning on the AMA HIV staff, but the AHCPR document is much longer, about 100 pages, and "extraordinarily detailed." It includes information on how the panel arrived at each recommendation. The AMA document is about 35 pages long and focuses only on treatment. The AHCPR guidelines were developed by a private-sector panel of physicians, dentists, nurses, social workers, physician assistants, and a man and a woman living with HIV, while the AMA guidelines were developed by physicians.

Copies of "Early Evaluation and Management of HIV Infection," an accompanying quick reference guide, and consumer booklets may be obtained free of charge by calling 800/342-2437, or by calling AHCPR Instant FAX, 301/594-2800.

AMA Issues 'Stop Smoking' Guidelines

The AMA has released new smoking cessation guidelines, giving physicians a step-by-step approach to implementing a "stop smoking" program for their patients. "Patients regard their physicians as an important authoritative, credible source of information," said M. Roy Schwarz, M.D., senior vice president of Medical Education and Science for the AMA. "Communicating the risks of smoking is as important as educating patients about cholesterol, proper weight, or screening for breast cancer. We are not spending enough time educating our patients about the deadly nicotine habit." The AMA's guidelines have been endorsed by the National Cancer Institute and the Centers for Disease Control and Prevention. You may obtain a copy of the guidelines by calling Lydia Steck at 312/464-5372.

Report *continued from page 34*

No Geographic Service Areas

The final report drops the controversial proposal for geographic service areas that was in earlier drafts. This concept was developed to eliminate the possibility that ISNs might select only those areas that are relatively easy to serve and "cherry pick" good risks by "redlining" out low-income or geographically remote areas. The MMA and others argued that the service areas were too large for smaller start-up ISNs to service. The new draft proposes risk adjustment and reinsurance measures rather than geographic service areas to reduce incentives for ISNs to avoid risks.

Separate Entities

The report would allow existing health plans to operate ISNs as a "product line" without creating a new separate, corporate entity for the ISN, but the same reserves could not be used to satisfy the reserve requirement for both the ISN and the existing entity. Provider contracts would have to specify a provider's relationship with a future ISN.

No Guaranteed Issuance

The earlier drafts proposed insurance reforms, such as expanding the guaranteed issuance requirement to the individual market. In light of actuarial analysis, this provision was dropped. (See page 38.)

Office of Consumer Information

The report proposes the creation of an Office of Consumer Information to help enrollees of health plan companies understand their rights and to provide them with information on coverage options, subsidies for low-income persons, and health care purchasing pools. This new entity would operate within the Information Clearinghouse.

Some Rules Would Be Drafted Later

Repeal of Waiver Option

The MDH will seek repeal of the MinnesotaCare law that requires the implementation plan to include "a method to create an option for health care providers and health plans who meet or fall below the limits set by the commissioner" to obtain a waiver from the all-payer rules.

RAPO Assessments

The commissioner will submit proposed rules calling for a "user fee" on all-payer insurers to the Legislature during the 1996 session and seek adoption by July 1, 1996. The fee would reflect the state's investments in fee schedules, standard utilization review, and other regulatory and administrative functions provided for RAPO.

Public Health Goals

The commissioner will submit to the Legislature by January 1, 1996, recommendations on how providers and payers in RAPO should help achieve public health goals and will define the "core public health functions" that should remain the responsibility of state and local government. This language is intended to provide some comfort to county commissions that fear losing control over major parts of their budgets.

Essential Community Providers

The report proposes future rule-making to address the issue of essential community providers (ECPs) who would help ISNs serve high-risk and special-needs populations. ECP would have to be included in an ISN's provider network. The rules would establish criteria for being designated an ECP and would set the reimbursement. Following adoption of the rules, groups could apply for ECP designation for a period of two years. The ECP designation would be in force for no more than three years from the date it was issued.

Standard Benefit Set

Rule-making would also be used to develop and implement a comprehensive standard benefit set with up to five levels of consumer cost sharing. Effective July 1, 1997, an ISN or all-payer insurer would have to offer the universal standard benefit set to all enrollees. Dental services would be included. The commissioner of health in consultation with the commissioners of commerce and human services would develop the benefit set through rule-making.

Medical Assistance Phase-In

The commissioner of human services would develop a plan to incorporate the medical assistance program into the all-payer option and the integrated service network system. The plan would identify the federal waivers and approvals required, provide a schedule for phasing in medical assistance beginning July 1, 1997, and increase medical assistance reimbursement levels in stages during the phase-in period.

Solvency

The most divisive issue raised by earlier drafts was how stringent the ISN solvency requirement should be. The MDH report would require the commissioners of commerce and health to develop ISN solvency requirements based on a risk-based capital concept by January 1, 1996. • • • • •

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The MinnesotaCare 2 Percent Tax

Now that you can list the tax on patients' billing statements, the question is, should you?

Keith J. Halleland, J.D.

The dreaded time has arrived when Minnesota physicians must pay a 2 percent tax to fund MinnesotaCare, the state health system reform legislation passed in 1992 as HealthRight. A primary purpose of MinnesotaCare is to increase access to health care for uninsured and underinsured Minnesotans. Funding is provided through several sources, including an increased tax on cigarettes, a tax on HMOs, and the 2 percent tax on gross revenues of hospitals and other health care providers.

MinnesotaCare defines a "health care provider" for purposes of the 2 percent tax as any person furnishing medical, surgical, optical, visual, dental, hearing, or nursing services; drugs; medical supplies; medical appliances; or laboratory, diagnostic, or therapeutic services directly to a patient or consumer. Under MinnesotaCare, the 2 percent tax on hospitals and health care providers was phased in gradually. Minnesota hospitals became subject to the tax on January 1, 1993, and other health care providers became subject to it on January 1, 1994.

The 1992 Minnesota Legislature specifically addressed whether providers would be required to absorb the tax themselves. MinnesotaCare explicitly states that providers may pass the tax on to health care purchasers. However, the Legislature also specified that health care providers may not list the tax separately on bills to "individual patients."

The Legal Challenge

After MinnesotaCare passed in 1992, the health care community began to debate whether the prohibition against listing the tax on patient bills was a violation of providers' First Amendment right to free speech. Some people in the health care community speculated that litigation would be brought to challenge the constitutionality of the prohibition. Interestingly, no hospital challenged the prohibition before or after January 1, 1993, the effective date of the tax, perhaps concluding that the tax could just as effectively, or even more effectively, be "passed on" without such a legal challenge. In mid-1993, however, a physician, a pharmacist, and a dentist brought suit in Federal District Court in Minnesota, arguing that the prohibition against listing the tax on patient bills was a violation of their First Amendment rights.

On December 30, 1993, Judge David Doty issued a decision in *Bloom et al. v. O'Brien et al.* enjoining the commissioners of Health and Revenue from taking enforcement action against providers listing the tax on bills after January 1, 1994. Judge Doty agreed with the plaintiffs that consumers have a right to know the basis of charges in statements.

Without a doubt, Judge Doty's decision enforces providers' First Amendment rights. The commissioners unsuccessfully argued that, among other things, listing the tax might mislead consumers. The court found no evidence that the plaintiffs might actually disseminate false or misleading information regarding the tax, and it found there would be substantial harm to the public if the law was enforced as written.

Pitfalls of Listing the Tax

In light of Judge Doty's decision, a provider could easily conclude that listing the 2 percent tax on bills is the right thing to do. Certainly, Judge Doty concluded that health care consumers have the right to know where their health care dollars are going. At the same time, however, providers should be aware of a pending federal court case, *Boyle et al. v. Anderson et al.* In that case, 13 self-funded employee benefit plans have alleged that any pass-through of the tax to self-funded employee benefit plans violates federal law. Plaintiffs in *Boyle* claim that the Employee Retirement Income Security Act (ERISA) preempts any attempt to pass the 2 percent tax through to self-funded employee benefit plans. Plaintiffs also claim that various other provisions of MinnesotaCare relating to self-funded employee benefit plans are in violation of federal law.

Congress enacted ERISA in 1974 to provide uniform standards for the administration of employee benefit plans. These federal standards were intended to replace varying state laws regulating employee benefit plans. While ERISA does allow states to regulate insured plans, Congress explicitly prohibits states from enact-

ing laws that directly regulate self-funded plans.

In *Boyle*, the state does not dispute that plaintiffs are governed by ERISA. The primary issue in the case is whether the direct pass-through of the 2 percent tax is sufficiently related to self-funded plans to be precluded under ERISA.

So what does *Boyle* have to do with listing the 2 percent tax on patient bills? Plenty. In *Boyle*, the state argues that providers have the right to pass the tax through to plans as they would any other cost of doing business. In other words, simply because the tax is passed on does not mean that it is any more troublesome under ERISA than any other item of overhead, such as building costs and employee salaries.

What remains is a clash of legal principles, as well as provider strategies. Listing the tax on patient bills may provide self-funded plans with a better argument that the tax is unique and should be preempted by ERISA. On the other hand, not listing the tax and building the tax into patient charges may mean, according to Judge Doty's decision in *Bloom*, that health care consumers are being deprived of important information regarding their health care expenditures.

Unfortunately for providers, if a court decides that ERISA preempts a direct pass-through of the 2 percent tax to self-funded employers, the Minnesota Legislature would not necessarily have to change the statute's funding mechanism. The Legislature could decide, for example, that providers should simply absorb the tax, leaving Congress to resolve the ERISA issue. While it is possible that the Legislature might decide otherwise and change the funding mechanism, nothing is certain in that regard.

What remains, then, is a debate over whether to list the tax, with one point in favor of the First Amendment and one point in favor of protecting providers' rights to pass the tax on to consumers, including self-funded plans.

Until the court reaches a decision in *Boyle*, the answer to the debate is unclear. In the meantime, providers should, whenever possible, reach a voluntary agreement with third-party payers to pay the tax without a court battle. In the case of many self-insureds, however, the issues in *Boyle* may have to be resolved before it's safe to list the tax on bills. Until then, each provider in Minnesota should carefully consider whether listing the tax on patient bills is the right thing to do from both a business and ethical perspective. MM

Keith Halleland is chair of the Health Care Practice Group of Popham, Haik, Schnobrich and Kaufman, Ltd., in Minneapolis.

Itemizing the 2 Percent Tax: Practical Concerns

By Janet Silversmith

Providers have several options for handling the 2 percent tax, all of which raise practical concerns.

Charges vs. payments: A provider who itemizes 2 percent of charges may be reflecting an inaccurate amount of the obligation to payers and/or patients. The 2 percent tax is a gross receipts tax and is, therefore, based on reimbursement, which is often unknown until a claim has been processed.

Fee schedules: Many payers may have built the 2 percent pass-through amount directly into reimbursements; meanwhile, providers also may be increasing fees to capture the amount of the tax.

Information systems: Providers who itemize the 2 percent tax would likely have to make changes in their billing systems to track the tax. In addition, there is no billing code (HCPCS) for the tax, and submitting it as a line item would likely cause a payer to reject it as unrecognizable, which could delay payment. The creation of a local billing code would be of little benefit to providers who must also submit to non-Minnesota-based payers. Payers also face system obstacles if bills submitted to them are itemized; converting the submitted 2 percent amount (based on physician changes) to the amount based on reimbursements could be cumbersome.

Taxable services: Providers who itemize the 2 percent tax on bills will need to know which services are taxable and which are exempt from the tax. This could be difficult for many providers to do up front.

Other options: Other means of passing through the tax include retrospective billing, i.e., determining total amount of payments from a certain payer for a specific time period and submitting a bill for 2 percent of these payments, or itemizing the tax paid by payers on explanations of benefits (EOBs). Both options create difficulties for payers and providers.

Many providers have considered placing a message on the bottom of billing statements that says, for example: "Patients may notice an increase in charges due to a 2 percent tax on health care services. This tax, paid by providers, is used to help fund the MinnesotaCare program, which provides health care coverage for Minnesotans unable to obtain coverage on their own."

Given the complexities involved in many of the available options, it is critical that individual providers, in conjunction with third-party payers, determine which approach is most beneficial to them, both personally and professionally.

Janet Silversmith is a health policy analyst at the Minnesota Medical Association and is responsible for public health and reimbursement issues.

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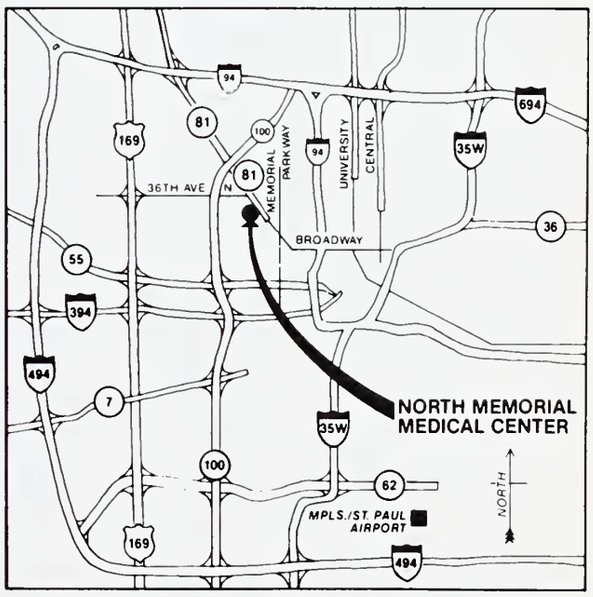

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John D. Barker, M.D.
University of Minnesota, 1940
Born: 1913, Died: Jan. 2, 1994

Lloyd Edward Carlson, M.D.
University of Nebraska, 1957
Born: 1932, Died: May 17, 1993

Vernon A. Doms, M.D.
University of Minnesota, 1946
Born: 1920, Died: Jan. 29, 1994

Hubert F. Flannery, M.D.
Rush Medical College, 1939
Born: 1914, Died: Jan. 12, 1994

Daniel W. Gaither, M.D.
Howard University, 1965
Born: 1939, Died: Jan. 17, 1994

Wayne S. Hagen, M.D.
University of Minnesota, 1935
Born: 1907, Died: Sept. 6, 1993

Samuel F. Haines, M.D.
Harvard Medical School, 1919
Born: 1892, Died: Oct. 7, 1993

Ernest O. Hanson, M.D.
University of Minnesota, 1929
Born: 1904, Died: Jan. 6, 1994

John A. Jensen, M.D.
University of Minnesota, 1954
Born: 1924, Died: March 4, 1993

Leonard F. Johnston, M.D.
University of Minnesota, 1932
Born: 1907, Died: July 27, 1993

Kathleen B. Jordan, M.D.
Case Western University, 1929
Born: 1901, Died: Aug. 21, 1993

Thomas J. Kirby Jr., M.D.
University of Texas, 1944
Born: 1917, Died: Nov. 15, 1993

Leslie A. Laikola, M.D.
University of Minnesota, 1941
Born: 1914, Died: Jan. 1, 1994

Edwin F. Luh, M.D.
Case Western University, 1949
Born: 1924, Died: Sept. 7, 1993

Donald O. Osborn, M.D.
University of Nebraska, 1946
Born: 1921, Died: Dec. 28, 1993

Nathan C. Plimpton Jr., M.D.
Rush Medical College, 1937
Born: 1910, Died: Oct. 29, 1993

Raymond D. Pruitt, M.D.
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The Devil in the Details

Issues to Resolve Before Reform Will Work

C. Randall Nelms Jr., M.D.

Affordable health care for everyone is a goal of the Minnesota Medical Association. To obtain this goal, we must have universal access, a guaranteed medical benefits set, and financing from an equitable, broad-based, stable funding source.

As health system reform takes shape, we must insist that high-quality care continue. Patients must have freedom to choose their doctors and maintain long-term relationships, if desired. The public should have health care security without government or big business mismanaging every step.

As we all know, the devil is in the details. Let's look at 10 points that must be considered.

• No new bureaucracies, whether big or small, should intrude upon the traditional physician-patient relationship. Reform should not result in a health care system dominated by three or four insurance companies or, in Minnesota, integrated service networks. Continued consolidation of market power ultimately could result in less choice for patients. We must promote physician-directed networks that allow physicians to realize savings and plan services with community benefits in mind. Physicians should assume responsibility for maintaining a high standard of quality and cost-effectiveness.

• Physicians must be able to negotiate fee structures with the giant networks that are forming. The MMA seeks the establishment of a formal negotiating entity that will "authorize physicians to organize and collectively engage in bargaining with third-party payers on a variety of issues related to the health care services provided by physicians, including, but not limited to, quality, accessibility, and price."

• We must avoid spending limits that restrict care, build more bureaucracy, and, as a result, invite deception. The MMA has voiced strong opposition to inflexible global budgets because they could lead to rationing.

"The public should have health care security without government or big business mismanaging every step."

• Medical decision making must remain in the hands of physicians rather than insurance companies and meddling bureaucrats. If giant health care systems are allowed to form, then physicians' ability to make medical decisions could be in danger. To maintain their ability to make appropriate clinical decisions, physicians must have a voice in the big corporate health plans. Better yet, physicians must be allowed to create their own plans. The MMA insists that physicians have direct involvement in the planning, organization, and management of health plans.

• National quality standards must be based on medical and not economic considerations. Health care cost containment cannot come at the expense of quality.

• Patients must be allowed to choose fee-for-service care. In Minnesota, physicians who choose the regulated all-payer option (RAPO) will offer such care. To guarantee that fee-for-service care is available, reimbursement under RAPO must be adequate so that it is a viable option for physicians. RAPO was conceived to provide a choice for providers and payers who feel they can manage costs and quality without an ISN.

• We must use caution in deciding how many primary care physicians and specialists should be practicing in the market. The successful implementation of health system reform will depend on an adequate supply of well-trained physicians in an appropriate specialty mix. Past studies have found shortages and surpluses in various specialties.

• The business of medicine should be simplified with standardized billing forms, streamlined administration, and elimination of hassle factors. Minnesota is establishing standardized forms and possibly a clearinghouse to sort and distribute claims.

• Medical liability reform should implement caps on jury awards and restrictions on attorney contingency fees. We should promote voluntary alternative dispute resolution for appropriate situations, expand collateral sources that may be considered an award, and allow for periodic payment of damages.

• Once universal coverage is achieved, we must ensure that services are actually available. It's not enough to say we have universal coverage and access; the care has to be available for everyone.

Before any kind of reform will work, we must work the devil out of the details. MM

CRUTCHFIELD

(continued from page 7)

"And I don't think any of the larger networks are addressing the problem that forcing these physicians into large groups will create. If you tell a poor, minority patient that she can no longer go to a physician whom she trusts or to a small community clinic with which she is familiar, and you tell her she must go to a large clinic across town, chances are she won't go, or she'll show up at the ER—which is the most expensive care of all."

A Solo Practitioner

Currently, Crutchfield is serving his second term as chair of the Ob/Gyn Department at United Hospital in St. Paul, where he also teaches ob/gyn to family practice residents. He maintains a busy solo practice—though he shares office space with a colleague and rotates call with three others—at a time when many independent physicians are thinking about retiring altogether or are joining larger groups or hospitals to survive.

"I love what I do," says Crutchfield, "and I work hard to stay afloat, often covering for other group practices and moonlighting at United." (He is also on staff at Children's Hospital of St. Paul and at all the HealthEast hospitals.)

It is the rapport with patients and the ability to make himself available to patients that Crutchfield loves about his practice—but he worries that these aspects of health care are being threatened by efforts to reform the system. "Larger insurers haven't given small practices enough credit for delivering quality health care efficiently," he argues.

"If I've been Mrs. Jones' doctor for 20 years, I know her history very well. I may know, for example, that she gets a periodic backache because she got it four years ago, at which time a neurologist saw her and an orthopedist saw her. X-rays were taken and things were fine. So if she calls in with a backache, I don't immediately order a CT scan and a neuro consult. I probably tell her to take some Tylenol and rest for a few days. But, the larger insurers aren't seeing that," he laments. "It doesn't go into the file that I just saved Medica $1,000. I'm not getting any credit for that."

Crutchfield says he still enjoys the obstetrics part of his practice and delivers about 15 babies per month. He sees approximately 23 patients a day, between his main office adjacent to United in the Fort Road Medical Building and his two suburban offices at White Bear Lake and Shoreview. He is quick to praise his five staff members, all of whom have been with him for more than a dozen years, and credits his office manager for success in seeking and maintaining strong relationships with a host of private insurers and HMOs to ensure that he is not dependent on any single source of reimbursement. Last year, for example, his reimbursement breakdown was 43 percent private insurers; 17 percent Physicians Health Plan, MedicaChoice, and other HMOs; 12 percent Blue Cross-Blue Shield; 14 percent Medical Assistance; 2 percent Medicare; and 12 percent cash.

Despite his own success practicing solo, Crutchfield predicts that, in the not too distant future, 90 percent of all practitioners will be in large groups, and within 10 years after that, many physicians and patients will be unhappy, and fragmentation will begin to occur. "The pendulum will swing back, away from commercialized medicine," he says. "More and more patients will be willing to pay to see the doctor they want and to have the hands-on care they need."

In the meantime, Crutchfield believes there will always be a percentage of practitioners who, like himself, enjoy practicing solo or with two or three others and will fight to survive. "Last summer, I took my family to Custer Park in South Dakota," recounts Crutchfield. "What was interesting was that every time we saw a herd of buffalo, there were always two or three who strayed from the herd. I think there will always be a few doctors like me who don't want to graze with the herd."

Crutchfield says he is happiest practicing medicine as a solo practitioner and plans to continue doing so as long as he can afford it—and can provide high-quality care. He knows there are skeptics who say he can't do it much longer. He doesn't have time to worry about them. He's too busy delivering babies, volunteering, spending time with his wife and kids, playing softball, skiing, and gardening, a hobby that speaks volumes about the excellent prognosis for Crutchfield's—and the community's—future.

"I love to garden. I've put lights up at home, and at night, I love to work in my garden. I like to grow unusual things that people say can't be grown in Minnesota—peaches, sweet cherries, seedless grapes, Asian pears. I've been told what I *can't* do for so long. 'You're poor. You're black. You can't go to medical school. You can't get a residency.' And, now, 'you can't grow *those* in Minnesota.' I just smile and keep on going." MM

Editors Note: In our conversations with Dr. Crutchfield, he emphasized his gratitude for the opportunities he's had in Minnesota and for the assistance and friendship he's received from numerous colleagues, among them: Dr. Cassius Ellis, Dr. George Schaffhausen, Dr. Joe Goldsmith, Dr. Konald Prem, Dr. Erick Hakanson, and Dr. Peter Fehr.

Fran Miller Toubin is a free-lance writer living in Minneapolis.

People and Places Making Medical News

People

Medical Society Honors Physicians

The Lake Superior Medical Society honored several physicians in Duluth during the society's holiday banquet. **Thomas A. Stolee, M.D.**, current Minnesota Medical Association delegate to the American Medical Association and past MMA president, was named Physician of the Year for consistently demonstrating qualities that patients and physicians recognize as defining excellence in medical care delivery. Stolee is a pathologist at Miller Dwan Medical Center in Duluth. The first female surgeon in Duluth, **Elizabeth Bagley, M.D.**, was honored with the establishment of the Elizabeth Bagley Merit Award, which was given to retired general surgeon **John B. Sanford, M.D.**, in recognition of his commitment to organized medicine through service to the Lake Superior Medical Society. Paleopathologist **Arthur C. Aufderheide, M.D.**, a professor at the University of Minnesota-Duluth School of Medicine, was honored with the establishment of an award in his name, the Arthur C. Aufderheide Scientific Award, and was also named the first recipient. **Linda Van Etta, M.D.**, an infectious disease specialist at the Duluth Clinic, was given the Educator Award for her efforts to educate people on the prevention of AIDS. **David A. Hutchinson, M.D.**, a family physician from Gateway Family Health Clinic in Moose Lake, and **Pamela Crouse, R.N., M.S.**, an educator at the College of St. Scholastica in the Nursing Department, were given President's Awards in recognition of noteworthy contributions to the field of medicine.

Women in Health Care Honored

A Minnesota Women's Consortium awards ceremony honored seven women for their contributions to Twin Cities health care. The January ceremony recognized **Betty Jerome, M.D.**, who recently retired as director of medical services for teenagers at Minneapolis Children's Medical Center. Jerome has advocated health care for street kids since the late 1960s. The consortium honored **Jean Harris, M.D.**, director of medical affairs for the University of Minnesota Hospital and Clinic, for her work to improve the quality of care in the health field. **Nicole Lurie, M.D.**, an associate professor of medicine and public health at Hennepin County Medical Center and at the University of Minnesota, was honored for her contributions to health care. Lurie researches health issues and works to improve health care to underserved minority groups.

The ceremony also honored **Kay Williams**, a nurse at St. Paul's Central High School; **Lona Brown**, a licensed practical nurse with the Indian Health Board in south Minneapolis; **Penny Winton**, founder of Pathways, a Minneapolis daytime drop-in center for people with life-threatening illnesses; and **Julie Sorenson**, who serves as a weekend hospice nurse.

MedCenters Re-elects Board

MedCenters Health Plan, a member of HealthPartners, has re-elected the following officers to its board of directors: **William Schoenwetter, M.D.**, of Minneapolis, chair of the board; **Steve Moscow** of Bloomington, vice chair of the board; **Charles Jacobson, M.D.**, of Bloomington, treasurer; **Sally Lannin** of Edina, secretary. **Mark Brakke, M.D.**, of Coon Rapids was elected a member-at-large of the executive committee.

Minneapolis ChildCare 1994 Board Members

Minneapolis ChildCare, Inc., the parent corporation of Minneapolis Children's Medical Center, has elected the following board members for 1994: **Elizabeth Bennett** of Excelsior, chair; **Lawrence Whalen** of Orono, chief executive officer; **Carolyn Schroeder** of Edina, secretary; and **Catherine Godlewski** of Minneapolis, treasurer. Other directors elected include: **John Colwell** of Golden Valley; **Susan Crutchfield, M.D.**, of St. Paul; **Joan Dayton** of Wayzata; **John Fangman, M.D.**, of Golden Valley; **Thomas Hinnenthal** of Plymouth; **Robert Howard** of Edina; and **Reid Johnson** of Minneapolis.

Minneapolis ChildCare is also the parent organization for Minneapolis Children's Foundation, Children's Health Care Services, Inc., and Minneapolis Children's-Ridges.

Blue Cross-Blue Shield Board

Blue Cross and Blue Shield of Minnesota has restructured its board of trustees to prevent conflicts of interest between board members and the corporation. The changes are also intended to provide additional flexibility as health system reform unfolds. Among the many changes, Blue Cross-Blue Shield has implemented a more rigorous screening process to avoid conflicts of interest and a new process for electing members. The board of trustees will be reduced from 19 to 13 members, and the new board will consist of a

consumer majority. Finally, BCBSM's president will now be able to become a board member.

Members of the restructured board of trustees include: **Karen M. Bohn**, managing director and chief administrative officer, Piper Jaffray Companies, Minneapolis; **John D. Buck**, vice president, administration, Alliant Techsystems, Hopkins; **Andy Czajkowski**, president and chief executive officer, BCBSM, St. Paul; **Terry S. Finzen**, president, Methodist Hospital, St. Louis Park; **John J. Jones**, senior vice president, Jostens Inc., Minneapolis; **Roger W. Kleppe**, vice president, human and administrative resources, National Business Systems, Inc., Bloomington; **James F. Knapp, M.D.**, Wahpeton Dakota Clinic, Detroit Lakes; **Mark S. Laub**, vice president, corporate services, United Power Association, Elk River; **Les L. Martisko**, executive director, South Central Educational Cooperative Service Unit, North Mankato; **Lawrence L. Mathias**, vice president, human resources and public relations, American Crystal Sugar Company, Moorhead; **Philip K. Olson, M.D.**, Affiliated Medical Centers, P.A., Willmar; **Roger R. Stearns**, president, Stearnswood, Hutchinson; **David C. Strafaccia**, director, finance and commission secretary, Hibbing Public Utilities Commission, Hibbing.

Places

HCMC to Offer Abortion Training

Hennepin County Medical Center will begin training medical residents in abortion procedures under a resolution passed by the Hennepin County Board in February. The resolution ends a 16-year ban on abortions at the center.

A public hearing on the resolution raised heated debate, with opponents arguing that tax money shouldn't be used to fund abortions. Two medical students pointed out that abortion training is "virtually impossible" to obtain. Four of the seven commissioners voted in favor of the resolution.

Mayo Building Children's Hospital

Mayo Medical Center recently announced it will build a $13 million hospital for children and adolescents within Saint Marys Hospital. The hospital, scheduled for completion by the end of 1995, will occupy the third floor of the Mary Brigh Tower expansion and the second and third floors of the existing Francis Building. It will contain a pediatric intensive care unit, neonatal intensive care unit, an infant/toddler/child general-care area, and a separate adolescent general-care area to enhance family-centered care.

Mayo Clinic Receives Grant

Mayo Clinic has recently received a $500,000 grant from John Deere Health Care to further develop Mayo's Disease Management Strategies, which are outlines of care designed to guide treatment for specific diseases and disorders. John Deere Health Care uses these medical guidelines to improve the quality and cost-effectiveness of patient care delivered at the John Deere Family Healthplan, a staff model health maintenance organization in Moline, Illinois. Mayo uses the guidelines at family practice clinics in Kasson and Kenyon, Minnesota.

Guidelines for six diseases have already been developed: asthma/chronic obstructive pulmonary disease, breast cancer, ischemic heart disease, low back pain, biliary tract disease, and depression. At least four more medical guidelines are expected to be developed during the next 12 months.

Group Health Receives NCQA Certificate

Group Health, Inc., has become the first Minnesota health plan to obtain an "accreditation with recommendations" certification from the National Committee on Quality Assurance. NCQA conducts full-scale quality reviews and accredits health maintenance organizations in the United States. The accreditation process includes review of quality improvement, utilization management, credentialing, members' rights and responsibilities, preventive health services, and medical records. The NCQA awards four levels of accreditation to health plans it reviews: full accreditation (three years); accreditation with recommendations, which becomes full accreditation upon implementation of NCQA recommendations (one year); provisional accreditation; and non-accreditation. Less than 20 percent of all plans reviewed are granted either this level or full accreditation after the initial review.

Blues Starting Statewide Electronic Highway

Blue Cross and Blue Shield of Minnesota and Integrated Medical Systems, Inc., of Golden, Colorado, have formed a joint venture to provide an electronic link for all health care providers and payers in state and border communities. The computer network, called Minnesota MedCom, will allow participants to electronically send and receive x-rays and other diagnostic images, order lab tests, exchange patient information, relay text and voice messages, and share outcomes information.

The network is designed to lower administrative costs and cut paperwork to save time for patient care. To join the network, a participant will need an IBM-compatible computer, a telephone line, a modem, and a voice package. The Blues will provide the training and software free of charge. The network should be in place by spring.

Socioeconomics

Comprehensive Medical Care and HealthPartners Form Partnership

Comprehensive Medical Care (owned by HealthSpan) and HealthPartners have signed a 10-year contract to form a strategic partnership that includes health maintenance organization and preferred provider organization services. HealthPartners is the parent company of Group Health, Inc., and MedCenters Health Plan. Comprehensive Medical Care has 54 physicians and more than 40 paramedical and mental health clinicians providing primary and specialty care at five Twin Cities locations.

Pediatric Cardiologists Unify

Physicians from the Children's Heart Clinic and Pediatric Cardiology Consultants have announced a unification of their pediatric cardiology groups. The merged group, referred to as The Children's Heart Clinic, includeds seven pediatric cardiologists: Harold Katkov, M.D., Amarjit Singh, M.D., Gregory Wright, M.D., Allison Cabalka, M.D., David Burton, M.D., Frederic Stone, M.D., and Thomas Sutton, M.D. Hovald Helseth, M.D., a pediatric cardiovascular surgeon, is also a member of the newly expanded group.

Primary Care Physicians Form Network with HSM Associates

HSM Associates, a HealthSystem Minnesota member, has entered into corporate affiliations with five primary care clinics representing 10 locations and 30 primary care physicians that practice at Methodist Hospital. The unification, called Primary Physicians Network (PPN), will allow members to share administration and services while maintaining autonomy and personalized medical care at each site. The goal of the network is to expand primary care access, influence the market, maximize economies, and participate in desired health plans. PPN will also provide physician input into business decisions made by HealthSystem Minnesota through a PPN board of representatives.

Mayo Cuts Jobs

In an effort to adjust to recent health care changes and move toward greater efficiency, the Rochester Mayo Clinic announced 450 job cuts this year through attrition. The cutbacks will come

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from, and affect, the entire Mayo Medical Center and are expected to save the clinic $18.5 million annually. In addition, a group has been appointed to find ways to cut expenses for supplies and services by 5 percent, which is expected to save another $12 million annually.

HealthEast to Cut 300 Jobs

HealthEast is planning to eliminate 300 jobs and convert its Divine Redeemer Memorial Hospital in South St. Paul to a long-term care facility, according to a plan it announced in January. The hospital system is reducing 7 percent of its work force through early retirement programs, attrition, and some layoffs. It will need approval from the state Legislature to convert Divine Redeemer since the Legislature has a moratorium on new nursing home construction.

The hospital system hopes to save $20 million to help offset the loss of Group Health patients to St. Paul-Ramsey Medical Center, declining inpatient admissions, and lower Medicaid reimbursements. As of March 1, Group Health no longer refers patients to St. Joseph's Hospital in downtown St. Paul. Instead, it refers patients to St. Paul-Ramsey, which has merged with HealthPartners, parent company of Group Health and MedCenters.

HealthEast also announced plans to build a medical facility in the southeast metro area. It is negotiating for a site in Inver Grove Heights at the intersection of Interstate 494 and Highway 3.

Health Commissioner Announces Spending Limit

Consumers can expect a reduction in health care spending increases in 1994, down from an inflation rate of 10.8 percent in 1991 to 9.4 percent in 1994. Minnesota Commissioner of Health Mary Jo O'Brien announced the limit as part of health care reform efforts to contain excessive increases in health care costs.

"We implemented this limit to protect consumers from skyrocketing health care costs that are increasing faster than the state's overall rate of inflation," said O'Brien. "Along with Minnesota's other health care reform endeavors, it should save consumers over $7 billion by 1998."

The Minnesota Legislature authorized the commissioner of health to set annual limits on the rate of growth in health care spending in the 1992 MinnesotaCare Act as part of a comprehensive cost-containment strategy.

Eveleth Hospital Files Chapter 11

Eveleth Hospital Corp. in Eveleth, Minnesota, has filed Chapter 11 bankruptcy and is forming a plan to pay off its debts. According to bankruptcy papers, the hospital has liabilities of $500,000 to $537,000 and assets of $206,775. The hospital's board of directors decided December 23 to file for Chapter 11.

Fairview Foundation Approves Grant Funds

The Fairview Foundation board of directors recently approved 14 health-related grant requests totaling $261,800. Among the 14 grants are $5,000 for the Block Nurse Program, which helps senior citizens maintain independent living; $18,000 for each of the next two years for the ENCORE Breast Cancer Program to expand support groups to the communities served by Fairview Southdale Hospital; $20,000 to Southside Community Clinic to support the establishment of a community clinic in the Powderhorn and Phillips neighborhoods; and $28,000 to Health Ministries for Inner City Older Adults to support existing health programs and explore development of a caregiver program.

Innovations

Mayo Develops New Lyme Disease Test

Mayo Clinic researchers have developed a reliable test that detects active Lyme disease, according to a report in the January 27 *New England Journal of Medicine*. Health officials believe the disease has been over diagnosed because current tests are not accurate—an expensive problem considering that aggressive antibiotic treatment for the disease can cost up to $17,000 a month and doesn't help patients suffering as a result of the body's immune response to the bacteria.

"This test offers doctors a powerful new diagnostic tool for patients whose Lyme arthritis has gone untreated or has failed to respond to standard antibiotic therapy," said David Persing,

M.D., in the Minneapolis-based *Star Tribune*. Persing is director of Mayo's Molecular Microbiology Laboratory, which developed the test.

The Mayo test uses polymerase chain reaction to replicate the gene sequence up to a trillion times; it can then be identified by lab personnel. Researchers at the New England Medical Center and Tufts University tested the accuracy of the procedure by using it on the synovial fluid of 73 Lyme disease patients who had not received treatment and on the fluid from 64 people who did not have Lyme arthritis. It detected the bacteria in 70 of the 73 infected patients, a success rate of 96 percent. The test was negative on all 64 who did not have active cases of the disease.

Persing and his colleagues are now trying to develop accurate tests for Lyme disease patients with neurological problems and those in the early stages of the disease.

Mayo Saves Two Lives With One Liver

Physicians at the Mayo Clinic saved two lives with one liver in a rare split-liver transplant operation in January—the second such operation performed at Mayo. Doctors divided a donated liver and transplanted one part into a 3-year-old boy and the other into a 49-year-old woman. The liver regenerates itself in the donor's body, usually in a matter of weeks.

The procedure is still considered risky and is only used for seriously ill patients, said Jeffrey Steers, M.D., a member of Mayo's liver transplant team. The boy was suffering from hepatitis that was rapidly destroying his liver. A donor liver was too large for his body, so doctors used part of it in a woman suffering from cirrhosis of the liver.

Medical Research

Plunger Device Better Than Hands for CPR

A modified toilet plunger is more effective than a doctor's hands for cardiopulmonary resuscitation, according to University of Minnesota researchers. Keith Lurie, M.D., who helped develop the device at the University of California in 1990 while on staff there, said it may preserve heart and brain tissue and save the lives of many heart attack victims. The California medical group developed the pump after learning that a toilet plunger had been used to revive a person whose heart had stopped.

Lurie's team compared the device, known as the Ambu Cardiopump, with conventional CPR on 21 patients who were having battery-powered heart defibrillators implanted. He said the pump got 20 percent to 50 percent more blood to the heart and lungs. A report on the study appeared in the February 10 journal *Circulation*.

AIDS Update

Public Health Service Publishes AIDS Treatment Guidelines

The U.S. Public Health Service has published a 196-page "clinical practice guideline" on how to diagnose and manage patients in the early stages of HIV infection. The guideline is an effort to help primary doctors provide routine treatment for the disease. "Some providers are reluctant [to treat HIV patients] for a variety of reasons," said Public Health Service Director Philip R. Lee at a news conference in January. Most physicians, he said, falsely believe HIV infection is too complicated for anyone but experts to manage. "By having the knowledge base in one place, at their fingertips, I think we'll overcome the major obstacle." For copies of the document, call 800/342-2437. MM

Chickenpox: To Treat or Not to Treat?

The chickenpox treatment controversy continues to simmer. The long-awaited approval of a chickenpox vaccine may further complicate the issue. The University of Minnesota and Park Nicollet Medical Centers are studying the effectiveness of immediate vs. delayed oral acyclovir treatment in adolescents and adults, and changes in viral susceptibility during treatment.

Study Design

Participants who are at least 12 years of age with rash of less than 2 days receive daily home visits and free medication. There is a clinic visit before and after treatment for examination and venipuncture.

For more information, call Henry H. Balfour, Jr., M.D., at the University of Minnesota (612) 626-5670, or Renner Anderson, M.D., at Park Nicollet (612) 924-1813.

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Manuscripts

Submit clinical articles, essays, letters, book reviews, and other manuscripts at any time to: Meredith McNab, Managing Editor, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. Manuscripts are reviewed by the editors and peer reviewed by the Advisory Committee, the Review Board, and other experts in particular specialties.

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A cover letter should identify the author with whom we correspond (include address and phone number). Double-space all text on one side of paper only, including references, legends, etc., and number pages consecutively.

Receipt of manuscripts is acknowledged within 10 days, and authors are usually notified whether their manuscript is accepted within one to three months, but longer delays are sometimes unavoidable.

Title and Authors' Names

The first page of the manuscript should include: 1) a title—make it short, specific, and direct, 2) the full names of all authors, with their academic degrees, 3) authors' positions in hospitals or other institutions—include current position and the position held when the work reported in your manuscript was done, as well as academic appointments and other information pertinent to the paper's topic.

Abstract

The second page of the manuscript should include an abstract no longer than 150 words that highlights for the reader the essence of the authors' work. It should focus on facts rather than descriptions and should emphasize the importance and uniqueness of the findings and briefly list the approach used for gathering data and the conclusions drawn.

Author Responsibility

All authors should be involved in the drafting, revision, and intellectual content of the manuscript and be sufficiently familiar with the paper to defend its findings. Authors are responsible for all statements made in their work, *including changes made by copy editors*. Manuscripts are edited for clarity and grammar and to conform to *Minnesota Medicine* style, and authors receive an edited, word-processed copy of their paper for their review before it is sent to the printer. Once it is set in galleys, only *minor* changes can be made.

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Use *JAMA* style or consult the AMA's *Manual for Authors & Editors*. Use generic drug names, unless citing a brand name relevant to your findings; brand names in parentheses may follow generic names if desired. Do not use abbreviations in the title, and limit their use in the text. Avoid medical jargon.

Tables

Tables must have a title and be on separate pages. If they occupy more than one page, type "*title* (cont.)." If the data in the tables have been previously published, appropriate reference should be given in the text, and permission should be obtained from the original publisher before submission to *Minnesota Medicine*.

Illustrations

Submit two copies of illustrations, keeping one for your files. Figures should be professionally drawn or photographed, if possible. We prefer glossy, clear black-and-white photographs, but color is acceptable if the contrast is good. Do not send original artwork.

Each figure should have a label pasted on the back indicating the figure number, author names, and the top of the figure. Legends should be included in the text of the manuscript with numbers corresponding to the figures. Do not mount figures on cardboard, write on the back of the figures, or attach paper clips to them. If a patient in a photo is identifiable, a written release form from the subject must accompany the photo.

References

All references must be cited in the text and should be arranged in the order in which they are cited in the text—*not* alphabetically. Journals should be abbreviated as in *Index Medicus*.

Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. Mayo Clinic Proc 1986;61:859-64.
2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. Dis Colon & Rectum, to be published.
3. Chaterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.
4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. Pediatric Surgery, 4th ed. Chicago: Year Book Medical, 1986: vol 1, 522-33.

Financial Interest

List all affiliations with or financial interest in organizations that may have a direct interest in the subject matter of your manuscript. This information will be held in strict confidence until publication, and then will be printed with the article as is deemed appropriate in judging the validity of the article.

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A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

MARCH 1994

Mar. 6-12 **Third Annual Minnesota/Costa Rica Medical Week: Diagnostic and Therapeutic Frontiers in Medicine** University of Minnesota and Autonomous School of Medical Sciences of Central America; Hotel Bougainvillea, San Jose, Costa Rica. CONTACT: Hugh D. Westgate, M.D., 800 East 28th Street, Children's Heart Fund, Minneapolis, MN 55407; 612/863-5460.

Mar. 7-11 **Medical Update 1994** University of Minnesota Department of Surgery, Continuing Medical Education, Medical School, and Continuing Education and Extension; Fort Lauderdale, FL. CONTACT: Medical Update 1994, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Mar. 10 **Medica Foundation/University of Minnesota Lecture Series on "The Task of Medicine: A Rich Past and an Open Future." Beethoven and Medical Practice in 19th Century Vienna** University of Minnesota Program in Human Rights and Medicine and Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Mary Krumholz, 1121 Marion Street, St. Paul, MN 55117; 612/487-9715.

Mar. 10-11 **Annual Family Medicine Today Conference** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Mar. 11 **Neonatal Resuscitation Program** Minneapolis Children's Medical Center; Minneapolis Children's Medical Center, Minneapolis, MN. CONTACT: Betsy Julius, Minneapolis Children's Medical Center, 2525 Chicago Avenue South, Minneapolis, MN 55404; 612/863-6206.

Mar. 11-12 **Advanced Life Support in Obstetrics (ALSO)** HealthSpan; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7910.

Mar. 14-16 **Myeloid Disorders: Updates in Clinical and Laboratory Hematology** Mayo Medical Laboratories; Snowbird Resort and Conference Center, Snowbird, UT. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Mar. 17-18 **Allergy and Clinical Immunology** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Mar. 17-18 **Critical Care: A Focus on Practical Management** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Mar. 18 **Minnesota Urological Society Pyelogram Conference** Minnesota Urological Society; Registry Hotel, Bloomington, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875.

Mar. 18-19 **Point-of-Care Testing/Phlebotomy** Mayo Medical Laboratories; The Stouffer Madison, Seattle, WA. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Mar. 19 **Symposium on Prostate Screening** University of Minnesota; Sheraton Midway, St. Paul, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Mar. 19 **Fourth Decade of Oral Contraception: Videoconference** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Mar. 19-25 **Radiology: Brain to Pelvis 1994** University of Minnesota; Pines Lodge, Beaver Creek, CO. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Mar. 24 **Medica Foundation/University of Minnesota Lecture Series on "The Task of Medicine: A Rich Past and an Open Future." Ethical Aspects of the Human Genome Project and Genetic Science** University of Minnesota Program in Human Rights and Medicine and Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Mary Krumholz, 1121 Marion Street, St. Paul, MN 55117; 612/487-9715.

Mar. 25 **Fifteenth Annual Occupational Medicine Update** St. Paul-Ramsey Medical Center; Minneapolis Metrodome Hilton, Minneapolis, MN. CONTACT: Bonnie Young, Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Mar. 25 **Infectious Disease in Immunocompromised Patients** University of Minnesota; Sheraton Park Place Hotel, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Mar. 25-27 **Third Annual Conference on Advances in Clinical Anesthesiology** Mayo Foundation; Amelia Island Plantation, Amelia, FL. CONTACT: Rita Kunz, Mayo Foundation, Section of CME, Siebens 5, 200 First Street SW, Rochester, MN 55905; 507/284-2509 or 800/323-2688.

Mar. 28-Apr. 1 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.

Mar. 31 **Progress in Health Care Reform: Minnesota and the Nation** University of Minnesota; Sheraton Inn Midway, St. Paul, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

APRIL 1994

Apr. 7-8 **Annual Ob/Gyn Update** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 7-9 **Nineteenth Annual Spring Continuing Education Seminar** Minnesota Academy of Physician Assistants; Holiday Inn-Airport, Bloomington, MN. CONTACT: Sonja L. Gedko, PA-C, 8575 Magnolia Trail, 203, Eden Prairie, MN 55344; 612/944-9388.

Apr. 8 **ENT Update** St. Paul-Ramsey Medical Center; St. Joseph's Hospital, St. Paul, MN. CONTACT: Bonnie Young, Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 8-9 **Pediatric Advanced Life Support** Minneapolis Children's Medical Center; Minneapolis Children's Medical Center, Minneapolis, MN. CONTACT: Betsy Julius, Minneapolis Children's Medical Center, 2525 Chicago Avenue South, Minneapolis, MN 55404; 612/863-6206.

Apr. 12-14 **Religion and Sexual Health: Norms, Boundaries, and Justice in Church and Synagogue** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Apr. 14-16 **Trauma of Upper Extremity Fractures and Dislocations of Wrist, Elbow, and Shoulder** Mayo Foundation; Scottsdale, AZ. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 507/284-2509 or 800/323-2688.

Apr. 15 **The 10th Annual Duluth Heart Conference** Duluth Clinic; Duluth Entertainment & Convention Center, Duluth, MN. CONTACT: Rockie Odberg, 400 East Third Street, Duluth, MN 55805; 218/725-3838.

Apr. 15 **Ventricular Arrhythmias** University of Minnesota; Earle Brown Heritage Center, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Apr. 15-16 **Seventeenth Annual Update in Clinical Cardiology** Minneapolis Heart Institute Foundation; Radisson Plaza Hotel, Minneapolis, MN. CONTACT: Don Young, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

Apr. 16 **The Treatment of Prostate Cancer** Minnesota Urological Society; Minneapolis Hilton and Towers, Minneapolis, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875 or 800/999-1875.

Apr. 21 **Medica Foundation/University of Minnesota Lecture Series on "The Task of Medicine: A Rich Past and an Open Future"** Program in Human Rights and Medicine, University of Minnesota, Continuing Medical Education; Grand Ballroom, Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Mary Krumholz, 1121 Marion Street, St. Paul, MN 55117; 612/487-9715.

Apr. 22-23 **Minnesota Orthopaedic Society 10th Annual Meeting** Minnesota Orthopaedic Society; Siebens Education Building, Rochester, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875.

Apr. 25-26 **Advanced Trauma Life Support (ATLS)** HealthSpan; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7910.

Apr. 25-29 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.

Apr. 25-29 **Family Practice Review and Update 1994** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Apr. 27-29 **Problem Oriented Case Studies in Surgical Pathology** Mayo Medical Laboratories; The Marriott, Amsterdam, Netherlands. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Apr. 29 **Agricultural Health & Safety** St. Paul-Ramsey Medical Center; location to be announed. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 29-30 **Pelviscopic Surgery Including Laparoscopic Hysterectomy** Abbott Northwestern Laser Center; Abbott Northwestern Hospital, Minneapolis, MN. CONTACT: Don Young, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

Apr. 30 **Minnesota Society of Pathologists Spring Seminar** Minnesota Society of Pathologists; Hennepin County Medical Center, Minneapolis, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875 or 800/999-1875.

MAY 1994

May 1-4 **Second International Congress of the Cell Transplant Society** University of Minnesota; Hyatt Regency Hotel, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 6 **Knee Arthroscopy Under Local Anesthesia** HealthEast; HealthEast Midway Hospital, St. Paul, MN. CONTACT: Annette Anderson, 1700 University Avenue West, St. Paul, MN 55104; 612/232-5190.

May 10 **Symposium on Gynecologic Oncology** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 11-13 **Current Concepts in Radiation Therapy** University of Minnesota; Mayo Memorial Auditorium, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 12 **Central Minnesota Medical Conference** St. Cloud Clinic of Internal Medicine, Ltd.; St. Cloud Holiday Inn, St. Cloud, MN. CONTACT: Kellee Zwilling, 1200 Sixth Avenue North, St. Cloud, MN 56303; 612/240-2155.

May 12-13 **Primary Biliary Cirrhosis: A Look to the Future** Mayo Foundation; Kahler Plaza Hotel, Rochester, MN. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME, Siebens 5, 200 First Street SW, Rochester, MN 55905; 507/284-2509 or 800/323-2688.

May 13-14 **Eating Disorders** University of Minnesota; Sheraton Inn Midway, St. Paul, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 18-20 **Delivering Integrated Medicine Under Managed Care: The Laboratories' Role** Mayo Medical Laboratories; Harold W. Siebens Building, Rochester, MN. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

May 19 **Sinners, Saints, and Health Care: Individual Responsibility for Health—Ethical, Legal, and Economic Questions** University of Minnesota; Humphrey Institute, University of Minnesota, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 19-20 **Minnesota Academy of Family Physicians Spring Refresher** Minnesota Academy of Family Physicians; Hyatt Regency Hotel, Minneapolis, MN. CONTACT: Miriam Case, MAFP, Interchange Tower, 600 South Highway 169, Suite 1680, St. Louis Park, MN 55426-1200; 612/542-0130 or 800/999-8198.

May 19-21 **Disability Evaluation & Management** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

May 20 **Emergency Medicine Conference** Duluth Clinic, Medical Education and Research Division; Duluth Entertainment and Convention Center, Duluth, MN. CONTACT: Rockie Odberg, 400 East Third Street, Duluth, MN 55805; 218/725-3838.

May 20-21 **Current Retina Practices for the Comprehensive Ophthalmologist** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

JUNE 1994

June 2-4 **Workshops in Clinical Hypnosis: Introductory and Advanced** University of Minnesota; Sheraton Inn Midway, St. Paul, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 2-4 **Controversies in Neurosurgery** University of Minnesota; Radisson Plaza Hotel, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 8-10 **American Society for Bariatric Surgery** University of Minnesota; Minneapolis Hilton, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 15-17 **Topics and Advances in Pediatrics** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 15-18 **Fifty-eighth Annual Surgery Course: Advances in Hepatic, Biliary, and Pancreatic Surgery** University of Minnesota; Willey Hall, University of Minnesota, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 17-18 **Mayo Ophthalmic Reviews** Mayo Clinic, Department of Ophthalmology; Mayo Medical Center, Rochester, MN. CONTACT: Darcie Skoda, Department of Ophthalmology, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; 507/284-1709.

June 24-25 **Critical Care Conference** University of Minnesota; Mall of America Grand Hotel, Bloomington, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 24-26 **Bone and Soft Tissue Review Course** University of Minnesota; Location to be announced. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington

Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

JULY 1994

July 7-9 **Chronic Lymphocytic Leukemia** Mayo Medical Laboratories; Silverado Country Club and Resort, Napa, CA. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

July 14-15 **Advanced Pediatric Life Support** Hennepin County Medical Center; Hennepin County Medical Center, Minneapolis, MN. CONTACT: Rachel Knudson, R.N., EMS Training, Hennepin County Medical Center, 701 Park Avenue South, Minneapolis, MN 55415; 612/347-3638.

July 15-16 **Synecologic Cytology** Mayo Medical Laboratories; Harold W. Siebens Building, Rochester, MN. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

AUGUST 1994

Aug. 5-6 **Bleeding and Thrombosing Diseases** Mayo Medical Laboratories; Mayo Clinic, Rochester, MN. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Aug. 22-Sept. 2 **Twelfth Annual Occupational Health and Safety Institute** St. Paul-Ramsey Medical Center; University of Minnesota, Mayo Building, Minneapolis, MN. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

SEPTEMBER 1994

Sept. 15-17 **Practical Surgical Pathology** Mayo Medical Laboratories; Harold W. Siebens Building, Rochester, MN. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Sept. 22-23 **Domestic Violence** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

OCTOBER 1994

Oct. 6-7 **Advanced Pediatric Life Support** Hennepin County Medical Center; Hennepin County Medical Center, Minneapolis, MN. CONTACT: Rachel Knudson, R.N., EMS Training, Hennepin County Medical Center, 701 Park Avenue South, Minneapolis, MN 55415; 612/347-3638.

Oct. 12-15 **Thoracic Organ Transplantation** Minneapolis Heart Institute Foundation; Westin La Paloma, Tucson, AZ. CONTACT: Don Young, 2810 57th Avenue North, Minneapolis, MN 55430; 612/574-7982.

Oct. 23-27 **Advances in Diagnostic Radiology** Mayo Foundation; Sea Island, GA. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

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Family Practitioner, Internal Medicine, Ob/Gyn, Pediatrician to join a progressive 13-physician group practice. Rural college town 30 miles from St. Paul, Minnesota. New clinic and new hospital. Contact Robert B. Johnson, M.D., River Falls, WI 54022; 715/425-6701. (*1/93-R)

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Mankato Clinic, Ltd. is seeking additional BC/BE physicians in the following specialties: orthopedics, radiology, invasive cardiology, oncology/hematology, family practice, and general internal medicine. The Mankato Clinic is a 59-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. M. P. Wheeler, President, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (10/93-R)

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MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

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Internal Medicine, Pediatrics, and Dermatology practice opportunities available at the Faribault Clinic. The Faribault Clinic is a multispecialty group practice of 19 physicians. Faribault is located 50 miles south of Minneapolis on I-35. For more information contact Ray W. Wood, M.D., or Ken Smith, Administrator, 924 NE First Street, Faribault, MN 55021; 507/334-3921. (4/90-R)

Stillwater: Twenty-physician multispecialty group with emphasis on primary care seeking BC/BE family physician. Scenic location with excellent school system, supportive medical community with strong local hospital, competitive salary and benefits. Send CV to Jon Pedersen, St. Croix Valley Clinic, 921 South Greeley, Stillwater, MN 55082; 612/439-2215. (9/93-R)

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Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

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Submit application to: **Craig Garrett, M.D., Division of General Internal Medicine, Department of Medicine, Hennepin County Medical Center, 701 Park Avenue, Minneapolis, MN 55415.** Deadline for submission: March 15, 1994.

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Wisconsin—Internist Wanted: Group Health Cooperative, a progressive, growing, primary-care group practice in a city of 60,000—90 miles from Minneapolis/St. Paul—is currently recruiting a third BC/BE internist. Very competitive salary with excellent fringe benefits. Practice high-quality internal medicine in a most desirable location. Please contact James A. Volk, M.D., Medical Director, Group Health Cooperative, PO Box 3217, Eau Claire, WI 54702-3217; 715/836-8552. *3-3/94

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Ob/Gyn—Minnesota: Progressive primary-care based multispecialty group seeking BC/BE obstetrician/gynecologist to expand current seven-physician, two-nurse-practitioner ob/gyn department. Located 20 minutes northwest of downtown Minneapolis, Minnesota, this area offers suburban living with easy access to an unlimited array of family, cultural, educational, and recreational opportunities. Members of our physician-owned and directed group earn a highly competitive income and excellent benefits including paid vacation and CME; pension and profit sharing plans; paid insurance; and partnership potential after one year. Please respond with CV to John Bordwell, M.D., Medical Director, Comprehensive Medical Care, 9055 Springbrook Drive, Coon Rapids, MN 55433; 612/780-9155. *1-3/94

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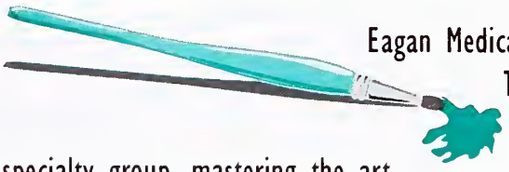

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Minnesota Medicine

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Where do you fit in the PHO puzzle?

APRIL 1994

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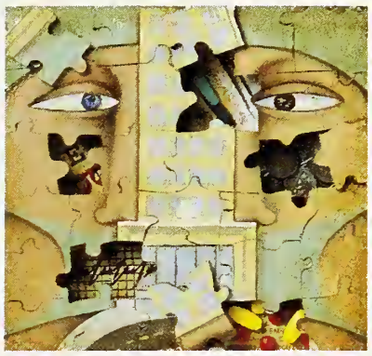

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Illustration by Gwendolyn Wong.

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More Physicians Accepting Acupuncture

I was pleased to see due attention given to alternative medicine in the February 1994 issue of *Minnesota Medicine* and agree wholeheartedly with the conclusions stated in Dr. Charles Meyer's editorial. The article written by Douglas Clement ("Considering the Alternatives") covered only the activities of the traditional Chinese medical clinic of Hennepin Faculty Associates managed by Patricia Culliton at Hennepin County Medical Center. There was no mention of incorporation of acupuncture in the Pain Clinic at HCMC by Dr. Miles Belgrade from the Department of Neurology. In addition to establishing use of acupuncture in the Pain Clinic, Dr. Belgrade has conducted a yearly "Acupuncture for Pain Control, Practical Course for Physicians" from 1989 through 1993. (Dr. Belgrade has recently left HCMC.) About 30 interested and open-minded physicians from Minnesota and from other states participated in this course; registration was always full, indicating the need for such training programs. A handful of physicians practice acupuncture in the Twin Cities, and effort is underway to organize an acupuncture study group with Patricia Culliton as a nonphysician participant.

Nationally, the American Academy of Medical Acupuncture boasts an increasing membership. Currently, more than 500 physician members are actively using "complimentary medicine" (a term preferred by M.D. acupuncturists over "alternative medicine") in their medical practices. The largest training program in the United States is at the University of California, Los Angeles. The Acupuncture Foundation of Canada offers well-organized training seminars and certification to participating physicians.

If alternative health care is popular and growing, and established medicine is taking alternative health care seriously, isn't it time for physicians to decrease their hostility and be open-minded skeptics? It may be surprisingly rewarding—it has been for me.

Sunanda Apte-Kakade, M.D.
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Chiropractic Article Misleading

Your February 1994 issue offered readers a choice of two different conclusions regarding the benefits of medical doctors recommending chiropractic health care for their patients. Douglas Clement's excellent cover story, "Considering the Alternatives," focused on the growing use of alternative health care and working relationships between providers. This article is another positive step toward breaking down barriers between the medical and chiropractic professions. On the other hand, Dr. Paul Brown's article, "Chiropractic: A Medical Perspective," in the same issue, is misleading and serves only to reinforce old myths and stereotypes about chiropractic care. A fair assessment of chiropractic today and the conditions between our professions requires a clearer report.

Fourteen chiropractic colleges are accredited in the United States. All chiropractic colleges are incorporated as nonprofit entities; one college is within a state university system. Chiropractic college curriculum is more like the medical model than Brown's article describes. For instance, the first two years of chiropractic course work are quite similar to medical school curriculum, including courses in anatomy, pathology, infectious disease, nutrition, etc. Most basic science courses in chiropractic colleges, like medical schools, are taught by faculty with Ph.D.s in their respective disciplines. Chiropractic colleges would no doubt include hospital rotations for their students if there were not bias barriers preventing this interaction.

Chiropractic adjustment is only one aspect of effective case management, as is any one tool in the medical armamentarium. Practices in most chiropractors' offices mirror diagnostic, treatment, referral, and therapeutic procedures familiar to medical practitioners, with the exception of the chiropractic adjustment. Among similar practices is radiological evaluation. Rational practitioners do not offer formulaic treatment plans based on x-rays; however, x-rays offer a perspective for evaluation of the applicability and specificity of adjustive procedures. Conditions and injuries not amenable to chiropractic treatment and management are routinely referred to appropriate health care providers.

Conservative care of spinal disorders is the cornerstone of chiropractic practice. Dr. Brown criticizes one of the basic tenets of chiropractic, the subluxation theory. Criticism of this theory and criticism of clinical outcomes, however, ought to be separated. Most practitioners graduating from accredited chiropractic

colleges design treatment plans based on a thorough diagnostic process. The subluxation is a diagnosis that, like many, is presumptive and may be modified based on clinical outcomes. Medicine certainly has a number of parallels to this: Its germ theory of disease is a narrow concept of pathogenesis that has proven on closer examination much more complex than originally thought. Disease processes viewed through different paradigms have been attributed to different influences and correlated to a variety of different types of pathology. Each has some aspects of truth and substantiation, and many are not completely understood. The temptation to discard theories we do not understand—but have not disproved—should be carefully considered.

Dr. Brown decries those chiropractic doctors who condemn and discourage scientific medical care. We would echo his alarm. Through improved dialogue between our professions, the success and shortcomings of all different types of approaches can be appreciated and improved upon.

The medical profession views with understandable concern efforts to review, modify, and curtail care undertaken by those without sufficient training. We share these concerns. Like allopathic providers, we view intraprofessional review by someone of like qualifications to be an absolute minimum.

There is a difference between being non-scientific and being a developing science. The benchmark is whether any profession developing its science holds tradition over scientific discovery and refinements. Both medicine and chiropractic are developing sciences and need to revisit time-honored traditions when research results dictate a new analysis. For the good of the patient, all professions in our health care delivery system ought to endorse efforts that reveal the effectiveness of different clinical outcomes.

Creating a truly multidisciplinary approach is perhaps the greatest challenge our health care reform efforts face. But our professions, and our patients, are ill-served by incomplete appreciation of the strengths of different approaches to health care.

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Dr. Brown Responds

The purpose of my article, "Chiropractic: A Medical Perspective," was to review and analyze the historical, philosophical, and research aspects of chiropractic. In contrast, Clement's article, "Considering the Alternatives," consisted largely of the opinions of various alternative practitioners.

The diagnostic and therapeutic training of primary care M.D.s and D.C.s are not comparable; medical training—two years of hospital-clinic clerkships and three years of intense residency training—far exceeds the didactic training chiropractic students receive in primary care. Training in a hospital, like practicing medicine, is a privilege earned by academic excellence and has little to do with "bias barriers." Legally, "chiropractic is not the practice of medicine" in Minnesota.

It is no "myth" that many chiropractors practice unscientifically; a casual review of various chiropractic magazines confirms that fact. Marketing pamphlets attributing the gamut of disease to subluxations are found in many clinics. As noted by Craig Nelson, D.C., of Northwestern College of Chiropractic, "At the very least, this faction represents a very large, vocal, and influential minority within chiropractic," (J Manipulative Physiol Ther 1993;16:280-1).

The "germ theory" evolved into the science of infectious disease through extensive, well-designed research. Palmer's nerve interference theory, the legal basis for chiropractic in this state, remains essentially unchanged and unproven after 100 years. Outcome studies support spinal manipulation only for limited low back, neck, and headache syndromes.

If the barriers between medicine and chiropractic are to fall, the chiropractic community must no longer tolerate, much less condone, the unsubstantiated therapeutic claims made to the public by some of its members. As a physician who has referred many patients to chiropractors for low back pain, I do not contest the therapeutic value of appropriately applied manipulation. Chiropractors will remain their own worst enemy, however, if they allow therapeutic claims to be made based on an uncompelling theory as opposed to scientific research.

Paul Brown, M.D., Internist
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The PHO Phenomenon

Charles R. Meyer, M.D.

Phee, Phi, PHO, Phum,
The age of managed care has come,
Hospitals, plans, and docs unite,
Is it time to all be glum?

Doctors have never been joiners. The doctor-patient relationship demands a privacy and independence that breed a love of autonomy in physicians that extends into managerial and business affairs. Doctors have linked with some organizations, but these traditionally have been professional associations, like the American College of Physicians, that have focused on education, or groups like the AMA that mix education with a large dose of professional advocacy. Relationships with the triple-letter threats, HMOs and PPOs, have been mostly arm's-length contractual connections. But now the perils of purchasing power have hurtled physicians into alliances previously thought unholy. The physician-hospital organization (PHO) wave is a local and national tsunami with far-reaching implications for the practice of medicine.

Five articles in this issue explore the PHO movement. Our introductory article, reprinted from *Indiana Medicine,* summarizes the general concepts of physician-hospital and physician organizations. The profile of Dr. Kathryn Love and the article by Paul Sommers provide glimpses of two local PHO efforts. The "report" from our Sooner exile, Dick Reece, describes his role in forming a PHO in Oklahoma and argues the advantages of collaboration between doctors and hospitals. A former president of the California Medical Association, Howard Lang, tells us why physicians should *not* collaborate with hospitals and *should* organize themselves.

"The perils of purchasing power have hurtled physicians into alliances previously thought unholy."

What does it all mean? Isn't the significance of the PHO movement about as clear as Minnesota River water? I offer these stabs at valid generalizations:

1. In the tradition of American retailing, PHOs have more flavors than Baskin-Robbins. PHO arrangements run the gamut from surgicenter joint ventures to IPAs. The current structures being erected in the Twin Cities include physician-only efforts, such as clinics without walls and Minnesota Specialty Physicians, and close hospital-physician collaborative efforts, such as the HealthSpan organization Dr. Love chairs.

2. Power is the main force driving PHO development and one of the stumbling blocks to their development. Small voices get smaller as government promotes ISNs and regional health authorities and third-party plans merge and gobble up providers. When physicians do start negotiating with one another or with hospitals, who controls the purse strings and who sits on boards become trust-testing decisions.

3. The push to organize shakes the traditional foundation of the physician psyche. The Jeff Goldsmith article Dr. Lang mentions says that "Physicians crave order but despise authority." If true, a major attitude alteration is necessary for doctors to cooperate in any organization where decisions about vital issues are made at some point distant from the individual physician's mind. Goldsmith believes doctors are "like lifelong bachelors contemplating marriage in their fifties ... [with] little experience with sharing, compromise, and delegation of responsibility."

4. Physicians need to realize that the game is different for all players, and, therefore, the incentives and goals may have changed. Established HMOs are threatened as businesses talk directly to providers. Hospitals are realizing that filling up beds is not a strategy for the future. The changing rules can be a threat or an opportunity for physicians.

5. The success for physicians in PHOs hinges on finding leaders they can trust and constructing organizations that remain responsive to the constituent physicians. In the dark ages of the 1970s, Twin Cities physicians organized Physicians Health Plan. By the mid-1980s the PHP leaders seemed inaccessible to member docs. Goldsmith argues for "collegiality within an organized practice" as a basis for enduring physician organizations. Whether that can be accomplished by hospitals and doctors working together, as promoted by Reece, or only by doctors allying with doctors, as Lang suggests, is an unfinished story. MM

In the Driver's Seat on The Road to Reform

Not one to sit back and let someone else make medical decisions for her, Dr. Kathryn Love now chairs HealthSpan's first PHO—this one physician driven.

By Pamela Hill Nettleton

Kathryn Love, M.D., believed in 1992 that physicians had about a year to establish an active leadership role in orchestrating health care reform. "If we do not take up the gauntlet," she said, "I think we will have to settle for being secondary considerations." Responding to her own challenge, Love became chair of Abbott Northwestern Hospital's physician-hospital organization that same year.

"I still want to be in active practice. I just had the idea that I'd rather participate in impacting major decisions that were going to directly affect how I practiced, rather than sit back and wait for someone else to decide them for me and for other doctors," says Love, an infectious disease specialist trained in Toronto.

The major decisions Love speaks of include reforming the health care delivery system, maintaining strong physician incentives through fair reimbursement, and controlling medical management initiatives sought by health care purchasers. Like it or not, says Love (and many other leaders in the field), the future will certainly include dramatic changes in how physicians practice medicine and in how patients receive treatment.

Physician Loss of Control

Love suggests that physicians are themselves responsible, in a number of ways, for their loss of control over health care delivery. In a speech to the Abbott Northwestern Physician Association, she enumerated them:

1. We abdicated our responsibilities to the "suits," who created a managed care bureaucracy that now accounts for as much as 27 percent of the premium dollar and has increased its costs 400 percent since 1980 (whereas the physician cost component of health care has remained stable at 20 percent during the same period).
2. We demanded that our hospitals purchase all the latest technology without regard for cost and benefit.
3. We watched as the hospitals bore the brunt of discounting and micro-management, and we did not take a proactive role in the business of medicine.
4. We hoped that it would all go away or that we could hold out long enough to retire and leave the next generation with the problem.
5. Above all, we were too busy competing with one another and maintaining the unique individualism that characterizes private practitioners to come together and articulate a common philosophy.

PHOTOGRAPH BY BRUCE BAIRD

"Physicians must empower their leaders and trust them, even though hospital corporations sometimes pay for their time."

–*Kathryn Love, M.D.*

Creation of Abbott's PHO

As purchasers of health care come together to combine forces and bargaining power, their provider wish lists include negotiating with one person who speaks for an entire health care delivery system, creating a long-term relationship with one organization, and establishing measurements for quality and value. Physicians who are not organized or equipped to negotiate in this manner may find themselves left out of the process altogether—and perhaps left out of key reimbursement and provider structures.

This need for effective negotiation and representation sparked the creation of the Abbott Northwestern Hospital PHO that Love heads. In 1991, a major care purchaser, an organization of 14 companies that self-fund health care, requested discussions with one representative who could speak for physicians and the hospital. To meet this request, which was seen as the wave of the future, Abbott started to develop its PHO.

"It was designed to help us be responsive in a competitive and rapidly changing market," says Love. "We wanted to organize now so we won't be scrambling later, reacting to health care reform and integrated service networks."

The PHO of more than 400 members is just one of four PHOs within the larger Integrated Physician Network created by HealthSpan (the merged Health One and LifeSpan hospital system), but it was the first and it leads the way for other physician-hospital alliances, according to Love. Abbott Northwestern's PHO enables the hospital and physicians to contract directly with employers and other health care payers, providing an integrated system of health care services and facilitating the use of managed care practices. Other HealthSpan hospitals are free to, and have, organized their own physician-hospital relationships. Each institution may differ, but standardized processes allow the system to negotiate and function as a whole, with common care standards, practice parameters, and fee structures. The Abbott Northwestern PHO is built on a physician-driven model, which Love says works to support primary care physicians, as well as specialists and subspecialists, and seeks to maintain the role of the physician as a patient advocate.

"One model of managed care calls for primary care physicians to be 'gatekeepers' for services, making referrals and helping patients access appropriate specialty care. One of our concerns as a PHO has been how to ensure better reimbursement for primary care. We want to attract and keep good primary care physicians," says Love.

Since purchasers of health care want quality care and controlled costs, Love feels it is imperative that physicians become involved in provider negotiations

LOVE continued on page 50

Visions and Missions Improving Medicine–*NOT!*

by Seymour Handler, M.D.

Medical centers (formerly hospitals) are speaking of "increased positive reinforcement" and instituting "total quality management"; Medical Records is now "Health Information Management." What does it all mean?

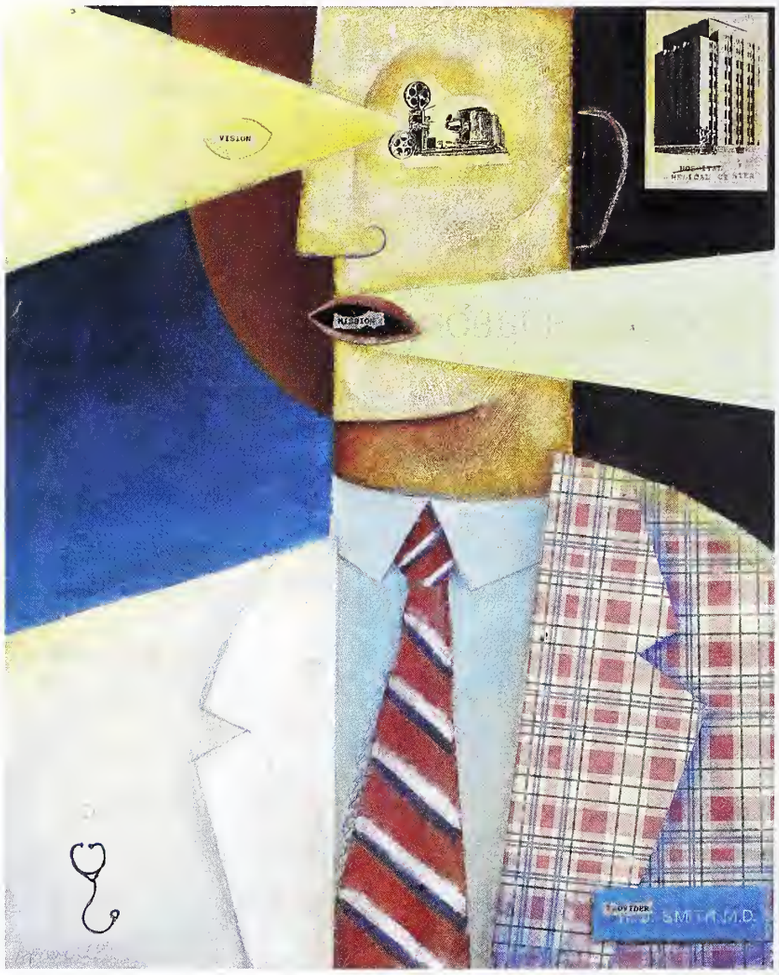


ILLUSTRATION BY ANDREW POWELL

Language is continuously evolving as each generation introduces or deletes expressions. Those of us with exposure to teenagers (not always a pleasant experience) recognize how youth is able to create new terms, often using them excessively and with little relationship to meaning. In recent years, teenagers moved from "cool" to "great" to "awesome" to express pleasure, and they used "gross" and "not" to describe negative feelings. Although young people are the experts at creating new expressions and terms with little discrimination or meaning, adults aren't bad either. We, too, distort language to excess, and perhaps with a greater loss of communication of ideas.

Health care settings are becoming havens for Orwellian Newspeak and other verbal gobbledygook. At one time, we practiced medicine in hospitals. Then the hospital became a "medical center," with no clear justification. Next, without making any obvious changes, the medical center developed "institutes" and "centers of excellence." Ordinary activity is now "on the cutting edge." At various committee meetings, we speak of "increased positive reinforcement," "appreciating the new challenges," and an infinite

number of expressions lacking in meaning. Practicing physicians are no longer doctors; we are providers (so are used car salespeople).

Whole new disciplines have developed from our attempts to enhance the value of what we do. In the past decade, hospitals (and a host of other enterprises) have been involved in TQM (total quality management) and CQI (continuous quality improvement). Is this new? Were we not previously dedicated to maintaining quality and improving our function? Aside from generating employment and taking up middle management's time, what has all this verbiage accomplished?

I wish someone would convince me that our considerable efforts formulating "visions" and "mission statements" are worthwhile. Does the creation of a hospital vision mean that we finally discovered what we should be doing? If we previously lacked a vision, how did we get the job done? Perhaps stumbling along without a vision permitted us to spend time doing meaningful work, with less time and effort expended promulgating a vision.

"Health care settings are becoming havens for Orwellian Newspeak and other verbal gobbledygook."

We also spend time developing "mission statements." Aren't mission statements a compilation of what everyone already knows, what is obvious to all, and simply a listing of salutary platitudes that make us look and feel good? Anyone who doesn't know our mission shouldn't be here. "Customer-friendly," a term extrapolated from a meaningful expression in the field of personal computers, commonly shows up in mission statements. In relation to hospital activity, it is an ambiguous expression, lacking in meaning. Creating a mission to be user-friendly suggests that we have heretofore been "unfriendly." Not only am I uncomfortable with that, but I dare say it is an inaccurate assessment.

The proliferation of meaningless gobbledygook seems to mandate a comparable increase in the number of people required to write and use the new verbiage. These people require titles, job descriptions, organization into committees, departments, functions, etc., etc. The resulting transformations are inventive: Medical Records is now Health Information Management; Dietary has become Nutrition Services; Building and Grounds is now Facilities Management; the Tumor Registry has been renamed Oncology Data Management; what was Housekeeping is now Environmental Services; Central Supply is Sterile Processing and Distribution (SPD). Surgical Pathology remains the same. Perhaps we should consider renaming our area Ultimate Diagnostic Center. Some of the new names reflect function in some way, but most reveal an attempt to upgrade the importance of the function performed by that department. What was wrong with the old names? At least everyone knew what they meant.

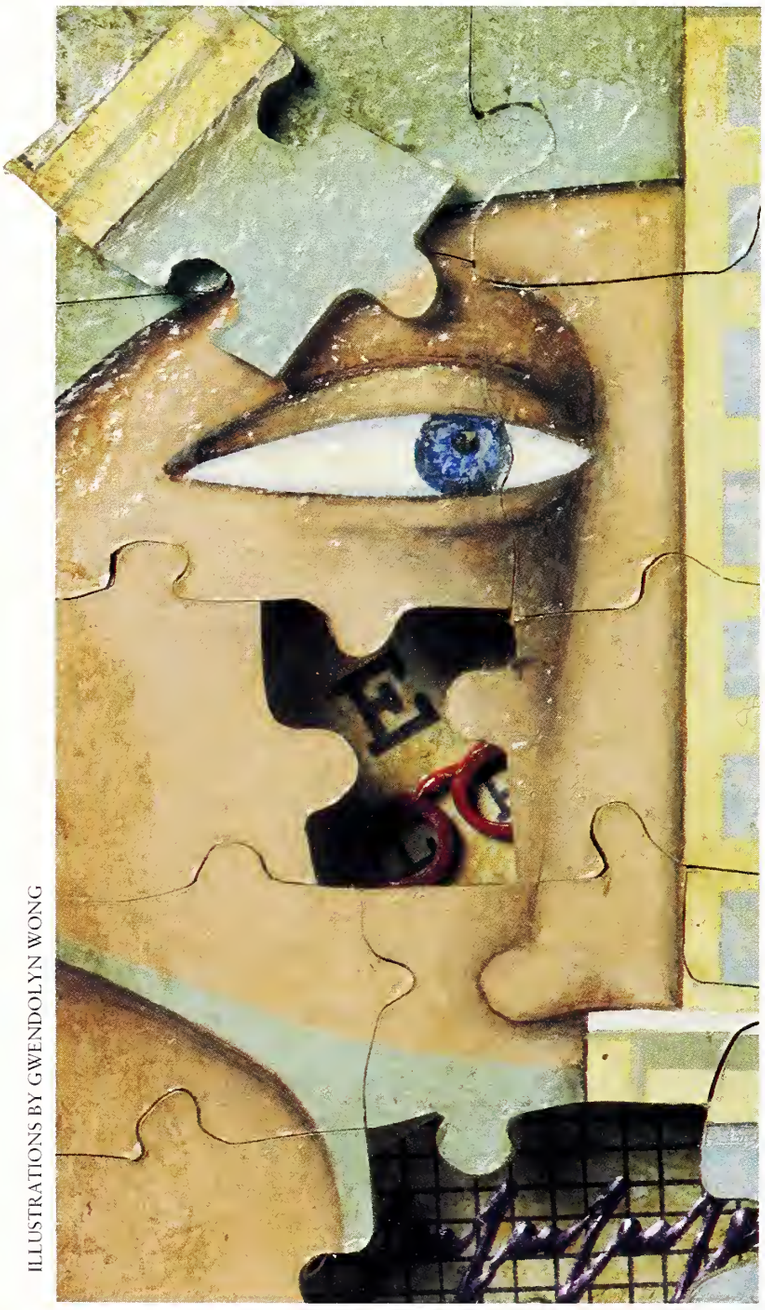
Despite a smaller number of inpatients, we have a proliferation of vice presidents, a massive increase in marketing and promotion, and whole new departments, such as QR (Quality Resources) and TQM, most of which have no apparent relationship to patient care. Because of budgetary problems (real or otherwise), hospitals attempt to reduce costs. How do we reduce costs? You guessed it. Patient care areas are asked (or told) to cut expenditures significantly; non-revenue departments either remain the same or increase. This observation, widely recognized, does not enhance the morale of personnel in patient care departments. I do not mean to imply that administrators do not work hard or perform their tasks effectively. The question I pose is whether all this talk, organization, and bureaucracy is necessary; does it fit the hospital's "mission"?

If one could calculate the time and money spent on TQM, CQI, visions, mission statements, think sessions, ad hoc committees, et al., ad infinitum, I'll bet the cost would run into seven figures, with much of the time expended by highly paid administrators. In the end, we wouldn't be doing anything differently than we did without all this verbal gobbledygook. Come on! Let's get the job done! Let's talk less about it. MM

Seymour Handler is a pathologist with North Pathology Associates, North Memorial Medical Center, and a member of the Minnesota Medicine *Advisory Committee.*

PHOs Can Lead to Strong, Profitable Relationships

By Robert Carlson



ILLUSTRATIONS BY GWENDOLYN WONG

How do you prepare for the emerging health care system?

Two options attracting considerable physician attention here in the Midwest and around the country are physician organizations, or POs, and physician-hospital organizations, or PHOs.

Some physicians are organizing themselves into POs. Others are joining forces with hospitals to form PHOs.

Is a PO right for you?
Or a PHO?
Maybe a PO and then a PHO?
The correct answer to all of the above is a resounding "That depends."

It depends on whether you are a primary care physician or a specialist; on your level of horizontal practice integration with other physicians; on your relationships with the hospitals with which you are affiliated; and on the market in which you practice.

Don't Wait for Washington

How you practice medicine in the future also depends on federal health system reform legislation, but not as much as you might think. By the time Congress passes it and the president signs it, what comes out of Washington is likely to have a lot in common with the innovative health care delivery systems that are now making history—and money—in the Twin Cities, on the West Coast, and in Albuquerque.

In these marriages of convenience, the physicians bring clinical expertise while the hospital provides administration, marketing, and capital.

. . . . . .

The reality is that the health care industry is in the midst of a historic change, a paradigm shift that's bigger than all of us. Think of it as a huge wave. If you decide to ride this wave of change, you'll be swept into uncharted waters. If you let the wave go by, you may find yourself treading water in the middle of the ocean.

For example, something like 80 percent of all PHOs exist on paper only, according to Nathan Kaufman, president of the Kaufman Group in San Diego, California. They are not viable, functioning business entities.

On the other hand, physicians on the West Coast who took a "wait and see" approach when POs and PHOs became popular there about 10 years ago are now experiencing "severe financial distress," according to Kaufman. His firm specializes in helping fee-for-service doctors succeed in a managed care environment.

What can we learn from successful, profitable POs and PHOs? What did they do that the others didn't? And why would doctors want to get into joint ventures with hospitals anyway?

What's a PO?

POs and PHOs are business entities created to take advantage of contracting opportunities by offering health care "products" that meet the needs of payers in the marketplace. Today, that means providing managed care services.

A PO, or physician organization, is a horizontally integrated organization of physicians. The spectrum of horizontal integration in a PO can range from a solo practice (no integration) on one end through shared office arrangements, an independent practice association (IPA), clinics without walls, a single specialty group, to a multispecialty group on the other end.

In an IPA, for example, physicians build their patient base by participating in managed care contracts but

continue to practice in their own offices. In a more integrated PO, such as a multispecialty group, physicians share expenses, profits, and office space. The group markets itself under a single name.

A PO can function as the physician component in the formation of a PHO. However, many PHOs are formed without first organizing a PO. Some well-known multispecialty group POs are the Permanente Group in California and the Lovelace Group in New Mexico.

"Managing care and assuming risk require a management infrastructure that most hospitals and medical practices don't have."

What's a PHO?

A PHO, or physician-hospital organization, is a vertically integrated entity formed jointly by a physician group and a hospital. When the physician group and the hospital have common goals, values, and a shared vision for health care in their community, working cooperatively as a PHO can serve the best interests of the physician group, the hospital, and the patients in the community.

PHOs are in the middle of the spectrum for integrated health care delivery systems, with "affiliation arrangements" or "management services organizations" on one end and foundations on the other. In a more integrated organizational structure, such as a foundation, there is more unity of purpose and a greater potential for managed care contracting. The trade-off is less autonomy for individual physicians.

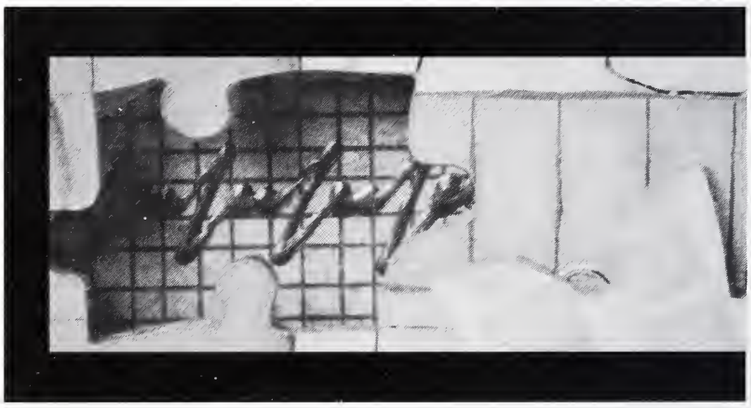
PHOs provide a relatively flexible, balanced approach to health care delivery at the local level that can be appealing to both physicians and hospitals. Some of the more well-known integrated systems are the Henry Ford Health System in Detroit, the Marshfield Clinic in Wisconsin, the Ochsner Foundation in Louisiana, and the Geisinger Foundation in Pennsylvania.

Each PHO is a custom-tailored entity, but some characteristics are common to all PHOs. The physician group and the hospital are equally represented on the PHO board of directors. The physicians bring their clinical expertise to the venture, while the hospital provides administration, marketing, and capital. Together, the physicians and the hospital have a much better chance of developing and marketing successful managed care "products" than they would separately. A marriage of convenience? Maybe. But with the economic incentives of both partners in alignment, a PHO can develop into a mutually satisfying and profitable relationship.

A Prescription for Success

The reason relatively few POs and PHOs make money is not because of any inherent flaws in the concept, says Kaufman. They are, however, very difficult to set up correctly. Managing care and assuming risk require a completely different computer system, a claims processing system, and a sophisticated utilization management system—in short, a management infrastructure that most hospitals and medical practices don't have. But infrastructure is only one ingredient in the prescription for PO and PHO success, according to Kaufman.

"What happens is that either the hospital administration or medical staff go to a seminar, and they come back and say we've got to get ready for health care reform and



managed care, so we have to create a PHO. They typically will then hire an attorney and put the organization together, and then nobody wants to buy the product. It's like setting up a factory before you decide what kind of product you want to make."

Thomas Gorey, president of Policy Planning Associates in Lakewood, Illinois, agrees. "Establishing a PHO just to establish a PHO will almost surely doom the venture to failure."

Policy Planning Associates provides health care consulting services to physicians, hospitals, and professional and trade associations. In the April 1993 issue of *Michigan Medicine*, Gorey identifies the following as key

factors in PHO success:

• Identification of need. The physician group, the hospital group, and the community identify common needs and interests.

• Shared vision and commitment. The physician group and the hospital articulate a shared vision of community health care that can best be achieved through physician-hospital cooperation.

• Shared financial stake. The physician group and the hospital each make more than a token financial commitment to the PHO.

• Clear identification of goals, objectives, and strategies. A well-articulated strategic plan sets clear goals, objectives, and strategies for the PHO, with measurable criteria for ongoing evaluation.

• Utilization of an appropriate organizational model. The PHO is designed to meet the unique needs of the physician group, the hospital, and the community.

• Clarification of roles and responsibilities. The PHO is structured to affirm the physician role in clinical decision making and the hospital role in business administration and marketing.

• Governance. The physician group and the hospital group have an equal voice in decision making.

• Avoidance of legal pitfalls. PHOs are not without financial and legal risk. The physician group and the hospital group should retain separate legal and business counsel.

It's a New Ball Game

In light of all this information, why are so many new POs and PHOs delivered stillborn? For the same reason that IBM didn't see the PC revolution coming and General Motors was late in developing fuel-efficient, quality cars, says Kaufman. "We're seeing a structural change of similar magnitude in the health care industry, and it's hard for the current market leaders to shed traditional paradigms and respond appropriately. POs and PHOs are not extensions of the current delivery system. They're new businesses and need to be planned accordingly."

"PHOs are in the middle of the spectrum for integrated health care delivery systems."

In other words, the paradigm has shifted. It's a new ball game with new rules. New Rule No. 1 is find out what the customers want to buy. Fee-for-service used to be the only game in town. In the new managed care environment, payers shop around for the best deal. "You either provide what the customers want, or they'll go someplace else to buy," says Kaufman.

"The first questions when setting up a PO or PHO," counsels Kaufman, "are what are we trying to accomplish, who are our customers, what do they want to buy, and how do we structure an organization not to be attractive to the medical staff or the hospital administration, but to be attractive to the payers?"

Gorey's prognosis for POs and PHOs in a managed care environment is cautiously optimistic. "Business is fed up with the cost of health insurance. I think the corporate community will be very supportive of POs and PHOs to the extent that they can demonstrate the ability to deliver high-quality, cost-effective care. Employers are clearly moving toward managed care, and it's going to affect virtually all physicians."

The New Rules

How will the shift to managed care affect you? In a primary care gatekeeper delivery system, for example, primary care physicians may be responsible for 70 percent of patient visits and are likely to feel entitled to a preferential share of the ownership and the profits. Most tertiary hospitals now have a 30-70 ratio of primary care physicians versus specialists. In most managed care capitated delivery systems, that ratio is 50-50 and is expected to continue shifting toward a 70-30 ratio over the next 10 years.

Where does that leave the specialists? One answer

may be to join PPOs. While most preferred provider organizations have fairly unsophisticated utilization management now, Kaufman thinks there will be substantial market opportunities for PPOs in the future.

Capitated managed care delivery systems such as HMOs depend on sophisticated utilization management systems to maintain their profitability. What happens to physicians who fall outside the norm, the so-called outliers? One strategy recommended by Kaufman is for both primary care physicians and specialists to contract with multiple POs and PHOs now.

But that advice isn't much help in identifying which organizations will still be around in a year. After all, there are plenty of POs and PHOs with no contracts and no revenue.

Kick the Tires!

Gorey and Kaufman advise anyone considering a PO or PHO to visit some that work. That doesn't mean visit a consultant, but actually go to a PO or PHO, "kick the tires," talk to the doctors, talk to the patients, talk to the payers, and look at the books.

Possible Side Effects

Even if a physician succeeds in contracting with several well-designed, profitable POs and PHOs, he or she can count on giving up some degree of autonomy as a physician. Down the road, there is also the possibility that some physicians may no longer be allowed to participate in a PO or PHO because their utilization patterns don't meet the standards established by the organization.

"PHOs provide a relatively flexible, balanced approach to health care delivery at the local level."

"When forming POs and PHOs, physicians tend to look at their colleagues in an evaluative sense," Gorey notes. "They ask themselves, 'Is this someone who's going to help us bring in managed care business? Is this someone who's going to help us practice cost-effectively?' If not, they have to make a business decision as to whether they want this physician to participate in their organization. I think most of them are going to be willing to make those hard decisions when it affects their pocketbook."

Some payers may simply prefer to contract with individual physicians rather than with a PO or PHO. Why? "Because they don't want to give an organization that much market power," says Kaufman. When it comes time to renegotiate the managed care contract in two or three years, taking their business elsewhere is not a credible option for payers because it means disrupting patient-doctor relationships.

What You Should Do Now

If you practice in a rural community, you may be able to postpone joining a PO or PHO because there is less competition than in urban and suburban markets. If you are within five years or so of retirement, you will have considerably less incentive to get into POs and PHOs than someone with 10 or 20 years of practice remaining. All other physicians, says Kaufman, should have joined POs and PHOs yesterday. "I think it makes complete sense for physicians to join multiple POs and PHOs as soon as possible, provided these organizations have good, sound business plans."

Gorey predicates his timetable on the penetration of managed care in a market. "Ideally, physicians should be making these types of strategic decisions when their market is not a highly developed managed care market. In a market that's 40 or 50 percent managed care, your choices are going to be limited because some of the less fully integrated models will not be capable of competing against some of the more fully integrated models."

Primary care physicians are in demand under managed care and they are in short supply, so it's no coincidence that hospitals have been buying primary care practices. (See "The Physician-Hospital Integration Sensation," page 44.) That brings up an important point to keep in mind when you choose people to advise you about forming a PO or PHO.

"It's important for physicians to make sure that whoever advises them in the process really has a neutral allegiance," cautions Kaufman. "For a PHO, the consultant usually will have to be paid by the hospital because this is not an inexpensive proposition. The allegiance of these consultants and lawyers should be to create the most competitive organization possible. That means they can't show preference to the hospital, or to the physicians, for that matter." MM

Robert Carlson is a health care communications consultant in Indianapolis. This article originally appeared in the January/February 1994 issue of Indiana Medicine.

On Collective Clout and Agents of Change

PHOs allow physicians and hospitals to act as equal partners to make the right things happen, says this always-visible leader.

By Richard L. Reece, M.D.

Hello, Minnesota physicians. How are you?

Three years ago I left Minnesota and resigned as editor-in-chief of *Minnesota Medicine* to journey to another place. I entered pathology practice at a 250-bed primary care hospital in Oklahoma City and became medical director of a small private laboratory.

Since I departed, I have devoted much of my time to physician-hospital organizations. I have:

- helped organize a PHO;
- become chair of Deaconess Clinical Associates, a PHO;
- assisted in developing a PHO market package consisting of unified bills for 150 hospital procedures associated with a network of 300 physicians;
- played a catalyzing role in organizing a "super-PHO" among four Oklahoma City hospitals;
- served as one of the three co-founders of the National Association of Physician Hospital Organizations;
- started a new national newsletter, *The PHO Report*;
- journeyed to other parts of the country to start 20 other physician-hospital organizations.

Why Have I Done These Things?

I have done these things because I wanted to prove to myself that physicians can be overall leaders. I wanted to demonstrate through my own actions that physicians and hospitals can take a proactive, constructive, and positive leadership role in reforming the health care system at the grassroots; that physicians and hospitals can create an integrated system; that physicians and hospitals can cut health care costs, document quality, and improve outcome; and that physicians and hospitals can engage the forces of managed care in such a way as to create win-win-win situations for physicians and hospitals, patients and payers, and the system as a whole.

Departing from Minnesota

When I departed from Minnesota after 25 years of practice, I left because I wanted to become more of an activist, more of a leader with clout, and more of a participant in the larger socioeconomic-political arena.

I wanted to make a difference—for physicians, for hospitals, for patients, and for payers. As a consultant and editor in Minnesota, I felt I was no longer contributing as a leader, that my yearnings to participate in bottom-up reform weren't being satisfied, and that physicians and hospitals weren't acting as equal business partners to make the right things happen, e.g., bring about lower costs, greater value, and more payer and patient satisfaction. I badly needed repotting.

I chose to leave Minnesota and to become a visible leader and agent for change, rather than a passive behind-the-scenes observer and a protector of the status quo.

And I chose the physician-hospital organization as a vehicle for bringing about change.

Why PHOs?

Why PHOs? After all, swarms of critics out there say:

- physicians and hospitals are the cause of, not the solution, to our cost problems;

• physicians and hospitals are rank beginners at assuming risk;

• physicians have no capital, and hospitals have no entrepreneurial skills;

• trying to force physicians and hospitals to become business partners is akin to mating a motley collection of undisciplined stray cats with a herd of lumbering, organizationally bound elephants;

• in a physician-hospital organization, hospital executives, being creatures of organizations and skilled in their machinations, will slam-dunk hapless and helpless physicians.

If you believe the latter, you have no business being a physician leader. Still, there's some truth to all these statements. PHOs are not for the faint of heart.

"Physicians and hospitals, collectively and as partners, have the power and resources to achieve bottom-up reform."

The Other Side

But another side exists. In most parts of this country, i.e., outside progressive, mature managed care markets, physicians and hospitals are still the economic health care mainspring in town. Physicians and hospitals directly consume 65 percent of the health care dollar and indirectly account for 80 percent to 90 percent of the money spent. In dollar terms, private practice revenues amount to about $200 billion and hospital revenues are another $400 billion.

Together, physician and hospital revenues make up *the* major industry in most towns, cities, and rural regions in this vast continental nation. Besides, in many parts of the country, physicians and hospitals are already *there*, familiar with each other, just waiting to be organized, while managed care organizations are foreign entities, waiting *out there* to sweep in on the attack or to be invited in by disgruntled payers.

Why not, I asked myself, at least *try* to bring physicians and hospitals together in collective entities—as hubs that provide rational, lower-cost, and integrated systems that cater to local payers and local communities? And why not do this at the local community level, at the grassroots, from the bottom up, where most of the politics, most of the dollars, and most of the action are?

The Rules of the PHO Game

But how? To make a long story short, what follows are a few principles we've obeyed and observed to achieve our dreams of making physicians leaders, of mating physicians with hospitals as equal business partners, and of bringing about a more rational, lower-cost, convenient system. None of these things would be possible without the help of my physician partners, open-minded hospital administrators, the president of our PHO, and payers eager to embrace alternatives to the traditional system.

In organizing our PHO, the administrator of our hospital, the president of the PHO, and our PHO board have agreed to certain ground rules for the PHO game. These rules are summarized by our PHO president, David Coombes, former president and chief executive of University of Minnesota Clinical Associates:

• Create an environment of absolute trust and openness between physicians and hospital. One can never spend enough time nurturing this process. Bridging history and varying points of view will be mandatory. Your ultimate aim is to develop a shared vision of the future between hospital and medical staff. Start small, with key "buy-in" players from both hospital and medical staff. Meet, meet, meet! Build consensus about future direction with this small group first, then move on to include larger blocks of participants. Bring in outside help if necessary. There is nothing more effective than having a medical staff hear directly from one of their own who has been through battlefield conditions elsewhere.

• Recognize that the PHO is really an entrepreneurial company whose principal purpose for existing, at least in the formative stage, is to market the hospital and enhance the practices of the medical staff. To accomplish these initiatives successfully, the PHO should be struc-

tured in such a fashion as to allow its people to be innovative and not burdened with process or bureaucracy. In short, the new (the PHO company) should be organized separately from the old (the existing hospital and organized medical staff). It should be a separate corporation with a life of its own.

• Open physician membership in the PHO to all who want to participate and who have been properly credentialed by the hospital. Experience has shown that about one-half of a hospital medical staff will participate initially in a PHO. Then, with a couple of successes, additional medical staff members will clamor to come on board.

• Structure the ownership of the PHO in such a fashion as to have physicians and hospital sitting at the board table in equal numbers, with equal votes and having contributed equal equity in capitalizing the PHO. This is the single most important factor in minimizing control problems.

On Thinking Alike

In these matters, David Coombes and I think alike. We believe physicians and hospitals, collectively and as partners, have the power and resources to achieve bottom-up reform, to act as an entrepreneurial force, to form their own integrated systems, and to interact from a position of strength with larger integrated entities dominated by HMOs. Separately, physicians and hospitals will be pawns and victims of integrated systems.

That's the News

And that's the news from the Woe-Be-Gone State of Oklahoma, where physicians are good-looking leaders, hospitals are strong partners, and their children, the PHOs, are above average. MM

Richard Reece is chair of Deaconess Clinical Associates, Oklahoma City, and former editor-in-chief of Minnesota Medicine, *1974-1990.*

The Bottom Line: PHOs Benefit Hospitals, Not Doctors

Physician beware! Clever new legal structures won't make capital-hungry hospitals good business partners.

By Howard L. Lang, M.D.

In these days of health care upheaval, hospitals are increasingly trying to integrate physician groups into their operations in an effort to improve their bottom lines. Their most drastic efforts include acquiring physician groups through employment in order to control physicians' use of hospital resources while locking in patient referrals. Another means hospitals are using to

control physicians is the formation of physician-hospital organizations. Many physicians believe that such arrangements are an ideal solution to maintaining autonomy as a practice group while gaining capital and management services from the hospital. I would argue that the only way physicians can assure optimal clinical outcomes and patient satisfaction, as well as retain business autonomy and clinical authority, is to come together in a financially integrated professional corporation. The only way we can respond to buyers trying to dictate health care purchases is through large, integrated multispecialty groups that can collectively negotiate the terms of such a relationship. If physicians are not fully integrated and in charge of their own destiny, they will become price and quality takers instead of price and quality makers.

In this article, I attempt to point out how the interests of physicians and hospitals are so disparate that physicians cannot possibly achieve their goals when working in partnership with a hospital.

Why Not Work With Hospitals?

Physician-hospital organizations (which usually turn out to be hospital-physician organizations) lead to a transfer of power and responsibility from the physician and the patient to the hospital. National health care reform will transform regional markets into managed care "food chains." Since physicians are at the center of any health care delivery system, they, not hospitals, must be at the top of the food chain.

Hospitals are the fattest fish with the highest costs, and they are the least nimble in positioning. Hospitals are merely vendors and should have a less dominant position in the food chain.

Jeff Goldsmith, a well-known health care consultant and futurist, points out in an article titled "Driving the Nitroglycerine Truck" that the architecture of health systems is not founded on physical assets like hospitals or health centers, but on organizations of health service professionals. He argues that the core enterprise of most existing integrated health care systems—Mayo, Kaiser, Henry Ford—is a large multispecialty group practice. In the small number of integrated health care organizations we have today, the hospital is truly an ancillary service—a capital-hungry, troubled cost center. The hospital is certainly not the nucleus of an integrated health care organization; it is instead a high-maintenance core asset, whose use must be rigorously limited in managed care arrangements. Goldsmith concludes that "those who seek to organize integrated health care systems are, unwittingly perhaps, the heralds of a post-hospital era of health care delivery." If his forecast is accurate, why would physicians want to link their economic future to hospitals?

The history of physician-hospital relationships is replete with episodes of attempted (and, at times, accomplished) control of physicians by hospital management. As sociologist and author Paul Starr has pointed out, the relationship between the hospital and medical practice has been the focus of a century of conflict. Clever legal structures and slick presentations will not erase a history of suspicion and mistrust. The conflict becomes full-blown when the physicians actually reduce inpatient hospital days. The economic incentives of physicians and hospitals in managed care are so disparate that to forge an economic entity with the hospital is an invitation to confrontation.

PHOs promote divisiveness

Those who advocate hospital-controlled networks stress medical staff profiles that provide information on physicians' ages and specialties as well as estimates of productivity on the basis of admitting and procedure volumes and payer mix. In developing the networks, hospital advocates stress using those physicians who are heavy users of the hospital and who are loyal to the hospital. This promotes divisiveness within the medical community, with the hospital serving as the focal point of each group's activities, rather than the county or state medical association. If only certain physicians on the medical staff are "selected" to participate in the PHO, this again promotes division within the physician community. When this happens, the physicians lose.

Another problem PHOs face is that non-participating physicians on the hospital's medical staff are concerned about their exclusion from the new arrangement. They perceive that the hospital favors some physicians over others (which it usually does), helping some of their competitors to succeed and/or taking away some of their patients.

Physicians have good reason for this concern in light of recommendations from the hospital literature. In advising its members how to capture physicians, the Health Care Advisory Board, a Washington, D.C., organization representing hundreds of U.S. hospitals, states: "When possible, target the 'best and brightest' physicians first, be willing to pay for them, and the rest will follow at lower prices." Another of its recommendations to accomplish physician control is to "institute a formal program to minimize physician resistance by involving

key physician leaders in hospital planning." It also advises appointing a medical director held in high esteem by physicians to act as liaison between the hospital administration and medical staff.

Affiliation with one hospital is a mistake

As health care becomes regionalized, it will be a disadvantage for physicians to be linked to a single hospital. If we lose our ability to create regional physician networks by being tied to one hospital, our negotiating clout will be diminished. Also, different hospitals in this new health system will choose different options involving levels of cost, providers, and services. Affiliation with one hospital puts all of the physician's eggs in one basket; if the hospital fails—as many will—the physician could be frozen out of the managed care market.

Meanwhile, hospital occupancy rates continue their steady decline. Just over 60 percent of hospital beds nationally are filled, according to the American Hospital Association. Physicians must have access to different institutions that will serve the needs of their patients and preserve their flexibility in the marketplace. Hospital beds will be mothballed, converted to other uses, and certain departments, such as emergency, obstetrics, and psychiatric, will be closed. On any given night, roughly 310,000 of the nation's 925,000 community hospital beds are empty, according to AHA statistics.

Vacant hospital beds are not cheap. Each vacant bed costs $30,000 to $40,000 a year in maintenance, staffing, and depreciation charges—or about 15 percent of the cost of a full bed. According to Gerard F. Anderson, director of the Center for Hospital Finance and Management at the Johns Hopkins Health Institutions, hospitals nationwide have 200,000 more beds than they need to meet peak demand, creating an additional cost of $6 billion to $8 billion a year. Care is shifting to the ambulatory setting. By the year 2000, some 90 percent of the surgery now performed on an inpatient basis in a hospital will be performed by physician groups in their offices. The Prospective Payment Assessment Commission has calculated that the number of procedures performed at ambulatory service centers skyrocketed from 377,000 in 1983 to more than 2.5 million in 1991.

Given all these problems, why would physicians want to be locked into one specific hospital?

PHOs allow hospitals to control physicians

Individuals come together in a business venture to obtain either capital or expertise. Hospitals tend to view joint ventures as a way to alter the behavior of, and exert control over, physicians. One hospital attorney, in a moment of candor, wrote that physicians can no longer be allowed to exert their traditional independence and patient advocacy role in the hospital. Instead, he said, physicians must be made partially financially responsible for equipping the hospital, and the hospital must be run more like a business—that is, with the physicians acting under the control of business people.

The primary, if not the only, benefit a hospital brings to the table is capital—cash, equipment, facilities, and personnel. However, in the face of vigorous enforcement of federal and state fraud and abuse laws, the hospital must obtain ownership/control of the entity in proportion to the capital it invests. Anti-referral and tax exemption laws restrict or prohibit the transfer of capital between a hospital and physicians. In other words, there is no "free lunch" for the physicians. If the hospital puts up most of the capital, it will own and control the PHO.

If the physicians capitalize and, therefore, own the organization, they, not the hospital, will control it. A physician-owned entity can negotiate and contract with a number of hospitals or "technical component" providers to get the best deal because it is not limited to working only with the hospital. A physician-owned entity has broader access to expertise and capital.

Hospitals and other advocates of PHOs claim that the hospital has the management expertise necessary to function in this environment; yet, the plight of today's hospitals certainly doesn't imply a great deal of management savvy.

Hospitals often tell physicians that they share control of a joint venture because the individual physician shares constitute 50 percent of the venture. This is illusory

control. Any experienced corporate attorney knows that when one party has 50 percent of the stock in a venture and the balance is spread among many others, the 50 percent entity controls. When you add to that the difficulties physicians face in attending meetings due to such circumstances as emergency calls, an equal number of directors does not guarantee an equal voice for physicians. Instead, it guarantees that the hospital always has a majority, since most voting arrangements require a majority vote from a quorum of approximately 60 percent of the board. In addition, many primary care physicians have been led to believe they will take control of PHOs, dominate the specialists, and have a voice equal

to the hospital's. An organized, fully integrated, multispecialty physician group will allow the doctors to speak with one voice when dealing with hospitals and will defeat this divide-and-conquer tactic.

Hospitals are out to maximize own profits

An entity controlled by hospitals, such as a hospital-run management service organization (MSO), IPA, or PHO, naturally seeks contracts that maximize hospital profitability, possibly at the expense of physician profitability. Managed care payers usually have limited dollars to pay for all patient care, thereby pitting the hospital against the physician for the larger share of the fixed pie. For example, if the hospital can negotiate a higher reimbursement per diem for inpatient admissions by offering lower physician reimbursement, is there any question how the negotiations will go for the physicians? To the extent the PHO is staffed primarily or exclusively with present or former hospital employees, their loyalty will be to the hospital, not necessarily to the PHO as an entity, and certainly not to the physicians.

Contract acceptance is another key issue. A PHO has little clout if doctors can opt out of contracts at whim. But, since the organization is composed of competing independent economic entities (the physicians), any attempt to make the contracts automatically binding on the participating physicians runs afoul of antitrust law. Criminal violations of the Sherman Act are felonies punishable by imprisonment for up to three years, with a minimum of four months, and fines up to $350,000 for individuals and $10 million for corporations. Civil actions result in treble damages, court costs, and attorney fees.

Physicians can be left with nothing

Because hospital-controlled entities, be they IPAs, MSOs, or PHOs, use their contracting and scheduling power to exercise more and more control over the individual physician's patient mix, any vestiges of the physician's private practice will be eroded and eventually lost altogether. What will the physician have left if he or she wants to withdraw from the group? The withdrawing physician is guaranteed little or no payment for the practice. Some of these hospital-controlled entities guarantee only a buy-back of the stock at the original purchase price without even reimbursing the physician for the accounts receivable contributed or the accounts receivable earned by the physician for the group, not to mention the value of the patient base. In addition, the entities frequently have a restrictive covenant clause precluding the physician from setting up practice in the vicinity for a period of years. Such tactics certainly don't foster the trust and collegiality some commentators say are the organizing principles of these new arrangements!

PHOs create fraud and abuse and IRS concerns

Potential legal problems exist with hospital-physician "bonding" (or is it "bondage"?) schemes. In General Counsel Memorandum 39862, published in December 1991, the IRS noted that hospitals that become involved in profit-driven ventures with physicians could jeopardize their tax-exempt status. While general counsel memoranda do not carry the weight of a statute or regulation, they do represent the IRS's current enforcement policy on an issue.

In GCM 39862, the IRS significantly restricted the definition of exempt purpose as it applies to hospitals. GCM 39862 states that a hospital must be able to show

that its activities, particularly joint venture activities, benefit the community and not just the hospital. The IRS adopted the position that economic survival is not a charitable purpose. To be legally tax exempt, a hospital must have some purpose for a joint venture with physicians other than survival. A physician-owned entity need not concern itself with "inurement" or other issues that complicate life for tax-exempt entities.

In an effort to combat fraud and abuse in the Medicare and Medicaid programs, Congress enacted fraud and abuse legislation in 1972 and included it within the Social Security Act. Seeking to curb the proliferation of kickbacks and bribes, this legislation prohibited the soliciting, offering, paying, or accepting of kickbacks or bribes in connection with the provision of services or items that are reimbursed through Medicare or Medicaid.

Court decisions have concluded that illegal remuneration includes the offer or payment of anything of value. Thus, a hospital's forgiveness of a line of credit and its provision of computers and software for tracking managed care contracts could be considered remuneration for physicians' referrals to the hospital and could, therefore, be in violation of the law.

Since the fraud and abuse prohibitions can be interpreted to prohibit otherwise legitimate transactions, the government issued "safe harbor" regulations. PHOs do not fall within any of the safe harbors. They are, therefore, subject to challenge by the Office of Inspector General (OIG).

The acquisition of physician practices also raises concerns about violations of the fraud and abuse laws because, as stated in a December 1992 letter from the OIG counsel to the IRS counsel, "Frequently, hospitals seek to purchase physician practices as a means to retain existing referrals or to attract new patient referrals to the hospital. Such purchases implicate the anti-kickback statute because the remuneration paid for the practice can constitute illegal remuneration to induce the referral of business reimbursed by the Medicare or Medicaid programs." Specific items that the OIG counsel believed would raise a question as to whether payment was being made for the value of a referral stream would include, among other things, payment for:

- goodwill,
- value of an ongoing business unit,
- covenants not to compete,
- exclusive dealing agreements,
- patient lists, or
- patient records.

The OIG counsel stated that payments for these items are particularly questionable if a continuing relationship exists between the buyer and the seller and the buyer relies, in part, on referrals from the seller. He concluded by stating that, "We believe that many of these arrangements are merely sophisticated disguises to share the profits of business at a hospital with referring physicians, in order to induce the physicians to steer referrals to the hospital."

Conclusion

There is no hard information on the fate of PHOs. I have heard through one consultant that about 30 to 40 such entities have failed. It has been reported that several PHOs in California have lost $3 million to $9 million in their first three years of operation. Sutter/Sac Sierra lost $10 million in its first year of affiliation, and 52 physicians left, according to another report.

Organizations that are physician led and physician driven, not individual physicians practicing in Brownian movement, will allow physicians to survive professionally and economically. We must develop our *own* organizations so that we will have an organizational culture compatible with physician values of professionalism and control and that will keep physicians (or their designees) in management roles.

Integrated physician groups should meet hospitals and third-party payers as equals, not as supplicants. We can only do that with groups of sufficient size and with the necessary management savvy. Hospitals have traditionally been "Houses of Hope" and places of healing, and they should remain such.

Physician integration can create an environment that allows physicians to work cooperatively to improve the final product, which should include optimal patient outcomes and patient satisfaction. Our goal should be a physician-driven health care delivery system that unifies participating physicians, improves access to health care services, controls costs, and promotes physician autonomy. At stake is who will control patient care in the future. MM

Howard Lang, an obstetrician/gynecologist, is past president of the California Medical Association (1991-92) and past chair of the American Medical Association Hospital Medical Staff Section (1986-1992). He currently is an alternate delegate to the AMA House of Delegates. He also lectures and consults with physician groups and medical staffs throughout the United States.

Physician-Hospital Integration Ramsey Clinic Style

Vertical integration and common goals have allowed these St. Paul medical organizations to streamline operations, pare costs, and increase referrals.

Paul A. Sommers, Ph.D., and Michael J. Luxenberg, Ph.D.

Amidst the economic and social pressures transforming medicine in Minnesota and elsewhere, three St. Paul health care organizations—St. Paul-Ramsey Medical Center, the multispecialty physician group Ramsey Clinic, and the Ramsey Foundation—forged in 1987 a new arrangement aimed at unifying the clinic's physicians with the hospital and improving their position in the medical marketplace. Under this new physician-hospital organization, the groups' health plans, financial and business activities, and administrative support functions were melded into one vertically integrated system—an arrangement that broadens financial and program resources, reduces unnecessary expenses, and avoids duplication.

Several forces inspired Ramsey Clinic physicians to examine the multispecialty group practice's position in the highly competitive Twin Cities health care environment. The group's reimbursement from government and other third-party payers was shrinking, its malpractice and general liability premiums were increasing, its competition was escalating, and it was confronting exclusivity agreements with HMOs and PPOs for select services.

A Brief History of the Group

In the fall of 1987, Ramsey Clinic consummated its integration as a subsidiary member of Ramsey HealthCare, Inc., a public benefit corporation established by the Minnesota Legislature. In the 1986 Minnesota Laws, Chapter 462, Ramsey HealthCare, Inc., was chartered to "engage in the provision and delivery of health care and related services." It now serves as the parent company of St. Paul-Ramsey Medical Center, Ramsey Clinic, and Ramsey Foundation—all not-for-profit 501c3 organizations—and coordinates the delivery of medical and health services to residents in the east Twin Cities metropolitan area and western Wisconsin. St. Paul-Ramsey Medical Center is a 435-bed, private, critical care, Level 1 trauma, teaching and research hospital located in downtown St. Paul. Ramsey Clinic is a multispecialty physician group practice with more than 250 FTE members representing all medical and surgical specialties. The clinic's patients are admitted to St. Paul-Ramsey, east metro hospitals, and community hospitals in Wisconsin (Amery, Osceola, and Baldwin). Ramsey Foundation supports the patient care, medical education, and research conducted by Ramsey physicians. The Ramsey organizations include more than 3,100 staff members and employees.

Why Integrate Physician and Hospital Services?

Before consolidation, the Ramsey Clinic physicians operated as a separate, independent, and often competing organization to St. Paul-Ramsey Medical Center, which before 1986 served as a county hospital. Competitiveness between the hospital and the Ramsey physicians caused a "trust" problem between the two groups, whose competitive energies could have been better directed. Rather than worrying about who should get credit for what service, the hospital and physicians needed to work on increasing market share for areas within the Ramsey organizations.

The medical center and clinic did not appear to be ideal business partners, with operating expenses higher than the community standard, generally $10 million to $15 million of uncompensated (charity) care, a poor reimbursement patient mix, and a costly educational program involving 500 residents and 500 medical students. Although burdensome, these factors also presented a challenge—an opportunity to provide quality care with lower reimbursement and to structure a teaching program blending traditional medical education programs with cost considerations in a managed care environment. Our goal in planning the consolidation was to deliver more quality services at lower cost.

Before the groups joined, the physicians and the hospital faced many complex issues and decisions at various levels. Duplicate services existed in all administrative support departments of the clinic, medical center, and foundation. Multiple computer systems, business offices, financial activities, marketing, planning, public relations, and administrative services contributed to excessive overhead.

What Changed as a Result of Integration?

A new philosophy

An operating agreement was formulated stating that the clinic, medical center, and foundation through their holding company, Ramsey HealthCare, Inc., would coordinate financial policies, programs, and activities after careful consideration of the financial implications. Duplicate services and functions were eliminated and a seamless, customer-oriented delivery system was created, reducing overhead expenses by more than $3 million annually. Figure 1 illustrates the Ramsey organizational structure.

Ramsey bonded legally into a unified family, inspiring the subsidiaries to examine each opportunity and problem from at least four points of view:

1. impact on the clinic;
2. impact on the medical center;
3. impact on the foundation;
4. overall impact on Ramsey.

All decisions are made to minimize negative effects (and maximize positive ones) on the organization as a whole. The goal is always to enhance Ramsey's overall performance.

The Ramsey approach has distinct advantages for dealing with health maintenance organizations, preferred provider organizations, and other agencies requiring the services of more than one Ramsey subsidiary. Before meeting with an interested outside agency, the clinic, medical center, and foundation staff jointly review their administrative and financial perspectives so as to appropriately position Ramsey corporate as negotiations proceed.

New leadership roles

Integration of the clinic and medical center led to a newly defined role for each medical department head. The chair of a medical department at St. Paul-Ramsey Medical Center and Ramsey Clinic has a joint responsibility to manage the affairs of the department on behalf of both organizations. The chair's general areas of responsibility include:

1. practice of medicine in the department's specialty;
2. teaching and research within the department and interdepartmental teaching as appropriate;
3. the business and personnel affairs of the department on behalf of the clinic and the medical center; and
4. integration of the department with each organization and with the other departments.

Both the medical center, through its formal affiliation with the university, and the clinic, through its employment of the faculty, are jointly responsible for assuring that the conditions of the academic affiliation are fulfilled. Each chair oversees this responsibility within his or her department's specialty.

Integration consolidated the functions of the medical director, whose authority and responsibility were combined into a single position representing all medical affairs for the hospital and clinic. The medical director must be a member of the clinic and appointed by both organizations' boards of directors. The medical director assures the quality and the implementation of medical programs in patient care, education, and research on campus and in outreach and branch clinic locations. Currently, the president of Ramsey Clinic is also the medical director.

The physician compensation committee includes nonphysician representatives from the parent company and St. Paul-Ramsey Medical Center's board of directors. Joint planning retreats focus on ways to better utilize scarce resources and to address common goals and objectives, which are regularly updated and reflected in an annual joint strategic plan.

Under the PHO arrangement, one vice president or director was selected to manage each joint function. If the individual selected was employed by the clinic, the second in command was chosen from the medical center and vice versa. This approach was applied to each area to create balance within the administrative structures of the organization. All original selections came from within Ramsey.

Staff members had the option of remaining on their current payroll or transferring to the employer of record for the integrated department. When possible, necessary staff reductions were accomplished through attrition.

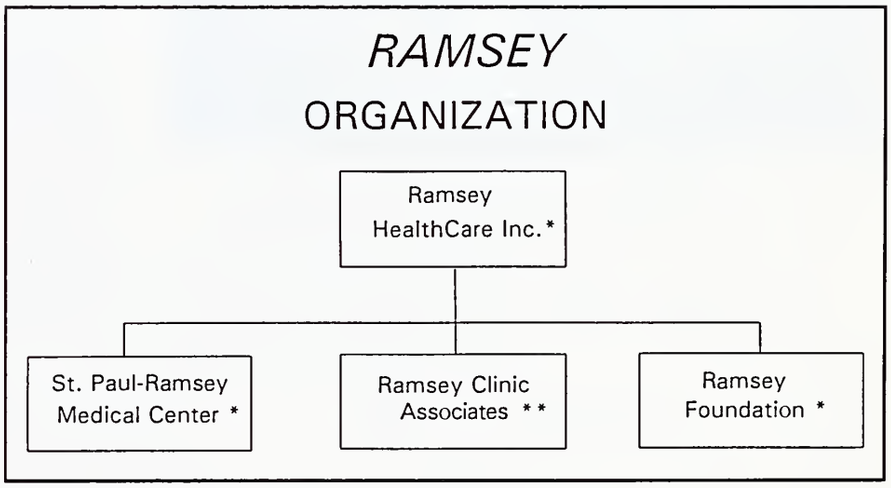


Figure 1–The Ramsey Organizational Structure

* The board is composed of 15 directors whose appointments are ratified by the board. Ramsey HealthCare, Inc., St. Paul-Ramsey Medical Center, and Ramsey Foundation each have the same directors and conduct monthly back-to-back meetings facilitated by use of a consent agenda. The current membership includes three Ramsey Clinic physicians and 10 directors representing the community and business organizations. Two seats are currently vacant.

** The Ramsey Clinic Board includes 13 directors who meet monthly. It is composed of nine physicians, all of whom are elected by the physician membership. The board is led by the clinic president/CEO. Ex officio appointments include the president/CEO of Ramsey HealthCare, who is also president/CEO of Ramsey Foundation, the president/CEO of St. Paul-Ramsey Medical Center, the senior vice president/CFO of Ramsey HealthCare, and the executive vice president/CAO of Ramsey Clinic/Ramsey HealthCare/Ramsey Foundation.

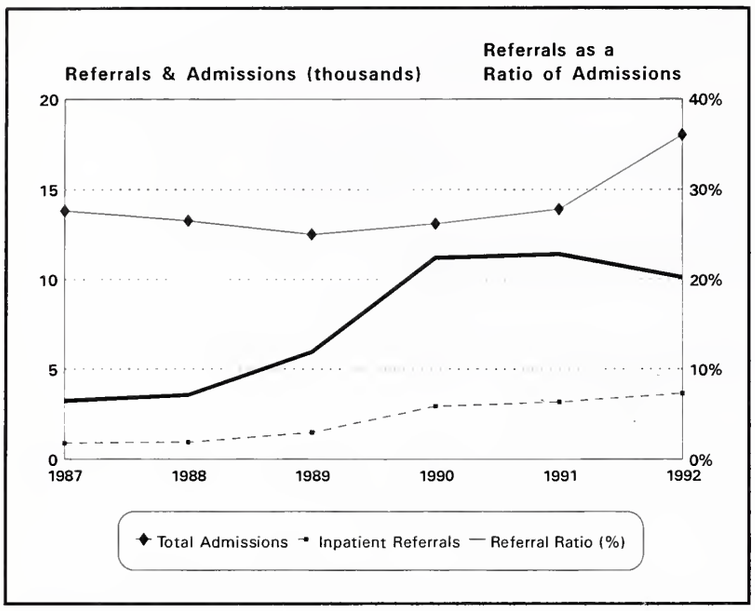


Figure 2–St. Paul-Ramsey referral volume as a ratio of admissions.

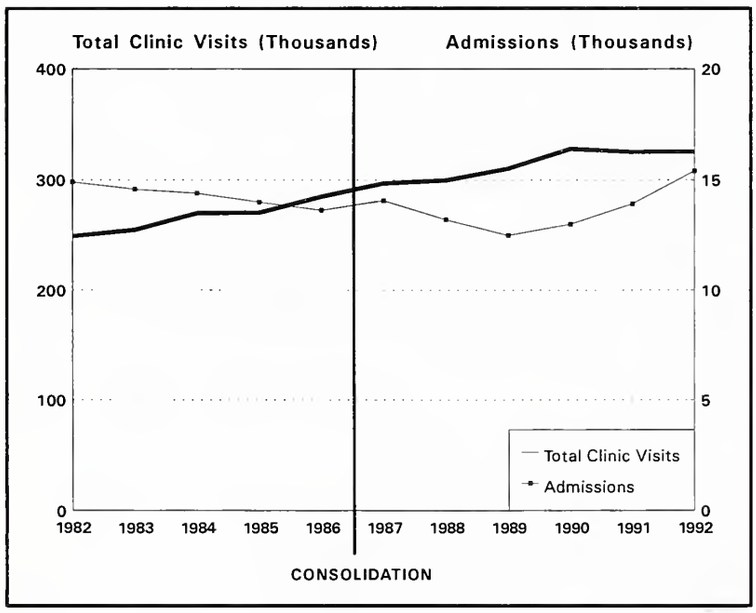


Figure 3–St. Paul-Ramsey total clinic visits by admissions.

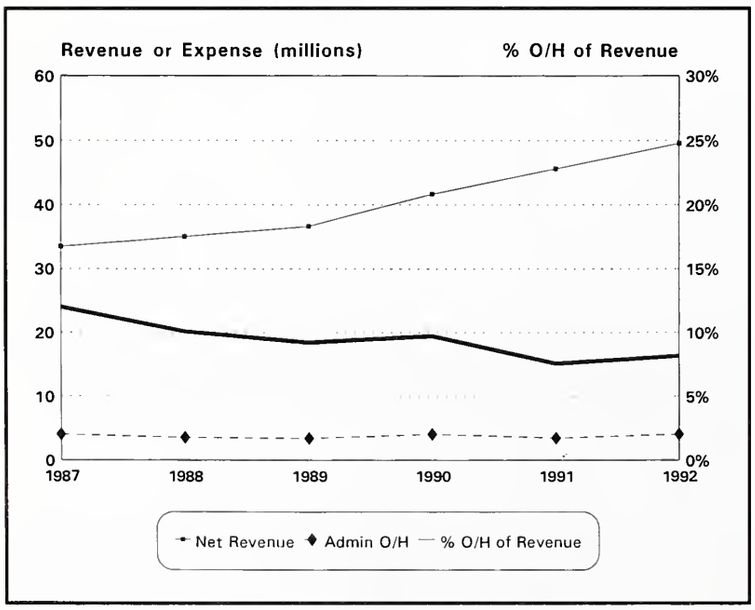


Figure 4–Administrative overhead reduction as a percentage of medical department new revenue.

Any layoffs followed the employer's layoff policy: seniority for the medical center, performance-based for the clinic. Expenses for consolidated services are prorated based on the ratio of current year Ramsey Clinic/St. Paul-Ramsey Medical Center budgeted operating expense.

The Results of Integration

The vertically integrated Ramsey health care system has demonstrated positive growth and stability as documented by the outcomes of a longitudinal study of performance measured from 1987 to 1992. The data studied include patient activity indicators, financial results, and business office results.

Admission, length of stay, referrals, outpatient visits

St. Paul-Ramsey Medical Center admissions and length of stay remained steady from 1987 to 1992, while inpatient referrals (from off-campus Ramsey physicians and non-Ramsey physicians) nearly tripled (see Figure 2).

Annual outpatient-ambulatory care clinic visits increased 10 percent (see Figure 3). Income from operations consistently improved from $1.7 million in 1987 to $4.2 million in 1992.

Administrative overhead

The reduction (and ultimate stabilization) of administrative overhead expense is of primary concern in this era of cost containment and health system reform. We have monitored administrative overhead expense in relation to medical department net revenue. In medical department budgeting, a certain amount of net revenue defined as "contribution margin" is required from each budget to support central business office and administrative services.

Ramsey Clinic administrative overhead, measured as a percent of medical department net revenue, decreased 32 percent from a beginning base of 12.03 percent in 1987 to 8.17 percent in 1993 without shifting costs to the hospital. This trend is indicated in Figure 4.

Physician compensation

To recruit and retain quality physicians, Ramsey Clinic closely monitors compensation and benefits. The physician organization participates in annual national and regional surveys and regularly uses the information to be competitive in recruiting and retaining both primary care and specialty physicians. Eliminating excess administrative overhead supports this initiative. Physician salaries now constitute more than 50 percent of the physician group's total operating expense budget. Physician turnover has been reduced from a 10-year average of 13.4 percent to 7.2 percent in 1992.

Combined revenue

As a vertically integrated health care system, the Ramsey physician-hospital organization has demonstrated steady growth. Coordinated revenue and expense trends are shown in Figure 5. Correlation analyses revealed how several key factors are related to the integrated group's combined revenue. The top four correlations we found are:

1) time: the relationship and success have become stronger with time;

2) referrals: the PHO has significantly expanded the referral base for specialty services and inpatient admissions;

3) physician compensation: increasing physician compensation by eliminating overhead expense has helped attract and retain quality physicians in this era of shrinking reimbursement;

4) outpatient ambulatory care clinic visits: expanding the primary care "feeder" system has allowed the group practice to continue to meet its mission.

Merger Between Ramsey and HealthPartners

Effective January 1, 1994, the Ramsey organization merged with HealthPartners, Minnesota's largest HMO, with more than 600,000 member enrollees. HealthPartners is the product of a merger between Group Health and MedCenters health plans in 1992. The Ramsey-HealthPartners merger is the first in Minnesota of a health plan and a hospital, and it signals plans for the first integrated service network in Minnesota, as defined by the 1993 MinnesotaCare legislation. We believe that the ISN will exemplify the kind of comprehensive health system that is needed to ensure affordable, customer-oriented, quality health care. Merging the hospital into a family of health plans furthers the vertically integrated structure established by Ramsey in 1987 and sets the stage for strict control of expenses by physicians, hospitals, and health plan network providers and staff.

Such expense control will be accomplished by redirecting care to fewer hospitals and physicians, shifting care delivery from the inpatient to outpatient setting, emphasizing primary care, reducing unnecessary hospitalizations, selectively using case management for hospitalized patients, using high technology and specialty services to more rapidly identify and resolve critical care problems, setting and adhering to financial and utilization "targets," and selectively reducing and restructuring certain care delivery and business systems. Although the health plans will go a long way toward providing the hospital and physicians a steady flow of patients, providers will need to use scarce resources carefully and manage quality care through an efficient delivery system focused on customer service.

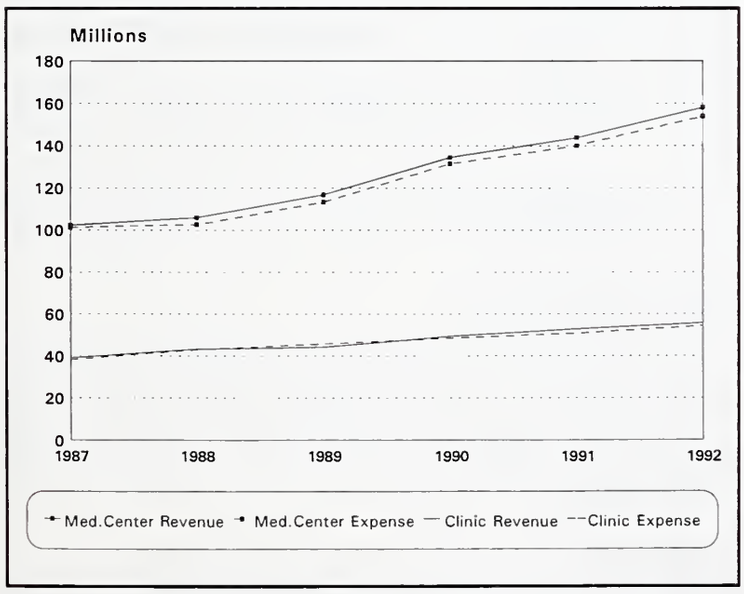


Figure 5–St. Paul-Ramsey and Ramsey Clinic revenues/expenses.

Why Is the Ramsey Physician-Hospital Integration Working?

Above all else, trust has driven the Ramsey PHO's success. Although each of the Ramsey subsidiaries has remained a separate 501c3 organization, a strong alliance predicated upon a common mission to serve pervades Ramsey. By jointly solving problems in an atmosphere of trust, we have achieved our annual joint strategic plan goals and objectives.

In summary, the Ramsey PHO has produced an increase in patients referred for inpatient care and multispecialty services, an increase in ambulatory care/outpatient services, and eliminated excess administrative overhead. By combining the resources of the participating organizations and streamlining operations to pare costs, Ramsey faces the next decade as a strong health care delivery system. MM

Paul Sommers is executive vice president and chief administrative officer of Ramsey Clinic in St. Paul. Michael Luxenberg is president of Professional Data Analysts in Minneapolis.

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1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. Mayo Clinic Proc 1986;61:859-64.
2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. Dis Colon & Rectum, to be published.
3. Chaterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.
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Bicycle-Motor Vehicle Collisions

Epidemiology of Related Injury Incidence and Consequences

Susan Goodwin Gerberich, Ph.D., David Parker, M.D., M.P.H., and Mark Dudzik, M.P.H.

ABSTRACT

This study investigated the incidence, consequences, and possible risk factors for injuries resulting from non-fatal bicycle-motor vehicle collisions during a one-year period in Minnesota. A study of 925 non-fatal collisions involving individuals 12 years of age and older in 1984 found an inverse relationship between age and collision incidence, with especially high rates identified for those between the ages of 12 and 14 (164 per 100,000) and 15 and 19 (71 per 100,000). Male bicyclists had consistently higher collision rates among all age groups. In a survey of the 925 individuals (64.3% response rate) 95% reported sustaining injuries as a consequence of the collisions. Twenty-one percent said they had not fully recovered from their injuries approximately two years post-injury, while 26% reported persistent problems. These results show a high incidence of collisions under certain conditions and suggest protective measures to make bicycling safer on our nation's roadways.

An increase in the popularity of bicycles in the United States for transportation and recreational use has been accompanied by a growing public health awareness of bicycle-related injuries and deaths.[1-5] In 1984, an estimated 106 million bicycles were in use in the United States; during the same year, approximately 1,000 bicyclists were fatally injured and another 40,000 non-fatally injured as a consequence of collisions with motor vehicles.[6] Estimates indicate there were 574,000 emergency department visits for bicycle-related injuries in 1985.[7] Of the fatally injured cyclists, 64% were 15 years of age or older; in 1960, this age group accounted for only 22% of bicycle fatalities.[8] For all ages combined, the male-female death ratio was approximately 4-to-1.[9]

Based on data from the Statewide Childhood Injury Prevention Program, Friede et al.[3] report that approximately 6% of injured cyclists (n=573) in their study required hospitalization. Penetrating and non-penetrating wounds accounted for 63% of the injuries. Fractures and cerebral injuries were the leading causes of hospital admission. Head, face, and central nervous system-related injuries accounted for 32% of all injuries and 62% of hospitalized injuries. This percentage approximates the figure cited by Guichon and Myles,[10] who report that 67% of the hospitalized cyclists in their study evidenced craniocerebral trauma. According to a study by Fife et al.,[2] head and/or neck injuries were associated with 86% of bicycle-related fatalities. Apart from the head, neck, and facial areas, the upper and lower extremities have consistently been identified as the sites most frequently associated with traumatic injury in bicycle-motor vehicle collisions.[4,7,10-14]

Of concern is that little is known about the long-term problems resulting from non-fatal injuries. In Minnesota, 1,282 bicycle-motor vehicle collisions were reported during 1984. Of the cyclists involved in these collisions, 1,258 sustained non-fatal injuries and an additional 15 died.[15] The purpose of this study was to investigate the types of injuries and the consequences, including persistent and disabling problems, resulting from these collisions during a one-year period in Minnesota, and to identify variables that might be associated with those injuries.

Methodology

A total of 925 cases, representing all individuals 12 years of age and older involved in non-fatal bicycle-motor vehicle collisions that were reported to the police during 1984,* were included in the study population. Data sources included the Department of Public Safety records on the 925 collision episodes and data obtained from pretested mailed questionnaires returned by 498 of the injured cyclists.

Data collection was initiated within 24 months of the reported events in an effort to gather accurate information on the consequences of resulting injuries, including persistent and disabling problems. A cover

* We would expect no change in the findings from 1984 data to current data. There has been no substantial change in the overall fatality rate since 1984. There are no adequate population-based data on helmet use that would enable estimates of any change on injuries to the head. In addition, based on research evidence to date, there has been no observable change in use of helmets for the age group studied, except in areas where helmet use is required by law and enforced; there is no helmet law in Minnesota.

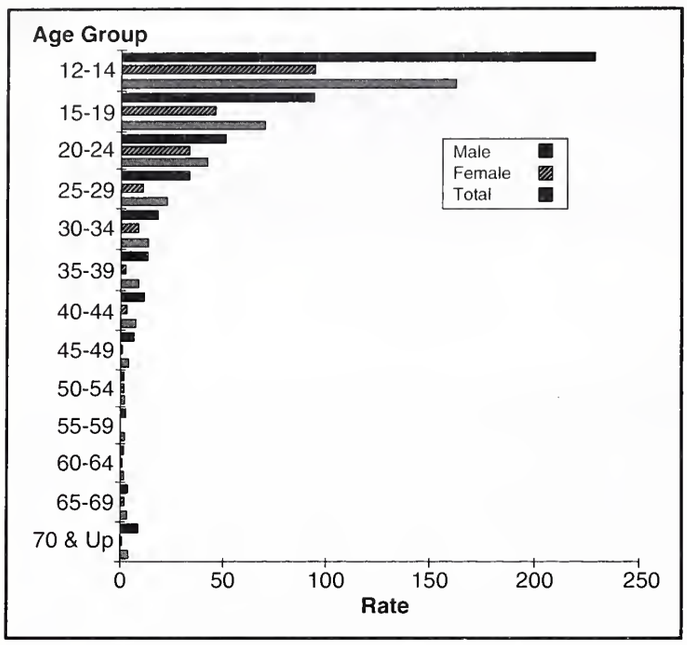

Figure 1–Minnesota bicycle-motor vehicle collision rates per 100,000 population by age and gender (1984).

letter outlining the purpose of the study, together with a questionnaire, an informed consent statement, and a stamped return envelope, was mailed to all subjects. The survey included questions concerning the nature and severity of injuries sustained in the bicycle-motor vehicle collision, as well as demographic information and characteristics of the collision. Up to five mailings were sent to nonrespondents. In addition, the names and addresses of health care providers seen for relevant injury care were requested to enable follow-up verification of reported injury diagnoses and associated anatomical sites.

Returned questionnaires were reviewed for completeness. In addition to the questionnaire, data pertinent to the collision and environmental conditions were incorporated from police reports. The injury rate calculations incorporated population data provided by the Minnesota Center for Health Statistics. Analyses were facilitated with standard statistical software packages and, for all statistical testing, a significance level of 0.05 was used.

Results

Of the 925 bicyclists studied, 498 returned a completed questionnaire; an additional 151 were returned as undeliverable, accounting for a response rate of 64.3%. Among the respondents, 66% were male cyclists and 34% were female. The breakdown was similar for all collision victims 12 years of age or older: 69% male and 31% female. The mean age of the total population of respondents (21.1 years) was also comparable to that of the total population of cases (20.5 years).

Forty-eight percent of the respondents were 16 years or younger at the time of collision. Thirteen- and 14-year-olds accounted for a disproportionate number of cases (12% and 14%, respectively), while 79% were 25 or younger. This was consistent with the total population of collision victims.

Figure 1 identifies rates by age for the reported bicycle-motor vehicle collisions. In general, there is an inverse relationship between age and collision incidence, with especially high rates identified for those between the ages of 12 and 14 (164 per 100,000) and 15 and 19 (71 per 100,000). Male cyclists had consistently higher collision rates among all age groups.

Of the total respondents, 95% reported sustaining injuries as a consequence of their collisions. This was similar to information provided in police files, which indicated that 98% of the total bicycle-motor vehicle collisions lead to injuries (73% "injured" and 25% "possibly injured").

Anatomical locations and types and severity of injuries

For male cyclists, the most common anatomical sites involving a single injury were the arm/hand (22%), leg/foot/ankle (20%), knee (16%), and head (14.5%). For female bikers, the most common injuries were to the knee (12%), arm/hand (11%), leg/foot/ankle (11%), and head (9.5%). The three most frequently identified sites with multiple injuries were similar for both male and female cyclists: arm/hand (13% and 9%), knee (11% and 6%), and head (11% and 7%). As shown in Figure 2, lacerations, concussions (loss of consciousness and/or loss of awareness/amnesia), and bruises were the three most common injury types reported by both male and female cyclists at single anatomical sites. The three leading types of injuries reportedly sustained at multiple anatomical sites were also identical for male and female respondents: bruises, lacerations, and sprain/strains. Treating physicians' information was in agreement with respondents' comments regarding diagnoses and associated anatomical sites 97% of the time.

Of the individuals reporting injuries, 76% said they sought medical care for examination and/or treatment of injuries. Severity of injuries ranged from mild to very severe, with the latter category including "permanent/unresolved" health problems (see Figure 3). Confinement post-injury was required for 44% of the injured victims and varied in length from less than two days (16%) to two days or more (15%) without hospitalization, while hospitalization was required for 14% of the injured bikers and ranged from less than two days (5%), to two to six days (2%), to one week or more (7%). At least 7% of the injured cyclists required surgery.

Among the respondents, 21% indicated that they had not fully recovered from their injuries approximately two *years* post-injury; an additional 7% indicated that they "did not know" whether they had fully recovered from the injury episode. This included 124 individuals (26%) who reported persistent levels of discomfort or other unresolved conditions that adversely affected their regular activities. Among the persistent problems identified were cases of paralysis (1%), paresthesias (5%), memory loss (2%), hearing disturbances (1%), visual disturbances (1%), scarring (9%), and, most commonly, residual pain (48%).

Temporal characteristics

Not surprisingly, the greatest proportions of bicycle-motor vehicle collisions were sustained by respon-

dents in the summer months of June, July, and August (19%, 24%, and 18%, respectively). The greatest proportion of bicycle-motor vehicle collisions occurred during mid-week (Tuesday, 18%; and Wednesday, 19%); the lowest frequency of collisions occurred on Saturday and Sunday (11% and 9%, respectively). Injury incidence peaked between the hours of 3 p.m. and 6 p.m. (34%). The hours between 12 noon and 3 p.m. and the hours between 6 p.m. and 9 p.m. accounted for 20% each. These findings are consistent with the distributions identified for the total bicycle-motor vehicle collision cases (n=925).

Roadway/traffic characteristics

Police reports identified road characteristics associated with the collisions. The majority of incidents occurred on roads that were characteristically straight and level (73%), and either two-lane (48%) or undivided four- to six-lane (28%) roads. Eighty-one percent of collisions occurred in areas where posted speed limits were 35 miles per hour or less, with 72% occurring in areas with posted speed limits of 30 miles per hour. Surface conditions on these roads were generally described by respondents as either excellent (31%) or good (44%).

However, road surface characteristics were identified as contributing factors in 21% of the collisions. These factors included sand/gravel (7%), steepness (6%), road curve (6%), uneven surface (4%), or wet surface (4%).

Most frequently, collisions occurred on municipal streets (44%) and county highways (29%). Fifty-nine percent occurred at intersections, 17% of which had no traffic control device. According to police diagrams of the collisions, 42% of the bicyclists were hit from behind, and 14% were struck by left-turning vehicles.

Helmet use

Among the total respondents, only 4.2% wore a helmet at the time of the crash. No significant differences in helmet use were identified between those who incurred brain concussions (2.6%) and those who did not (4.7%).

Discussion

No significant differences were found between respondents and nonrespondents for any of the host (age, gender) or environmental/temporal characteristics reported in police records. Other investigators have observed that bicycle-motor vehicle collisions, especially those involving no injury or minor injury and/or no or minor property damage, are generally under reported.[4,16] Thus, the findings of the current study likely characterize only a fraction of the total bicycle-motor vehicle collisions.

Our study showed that younger and male bicyclists have higher collision rates. This has implications for targeting prevention and control programs.

Although the overall death rates between 1977 and 1988 for bicycle-related injury in the United States decreased slightly, the proportion of adult bicycle-motor vehicle deaths steadily increased between 1960 and 1990. Adults 25 years and older accounted for 13% of all U.S. bicycle-motor vehicle deaths in 1960; by 1990, this proportion had increased to 45%.[8] As identified by Baker et al.,[17] the greatest increase, about 90%, occurred between the period 1977 to 1979 and 1984 to 1986 in the 35- to 44-year age group; the death rate for

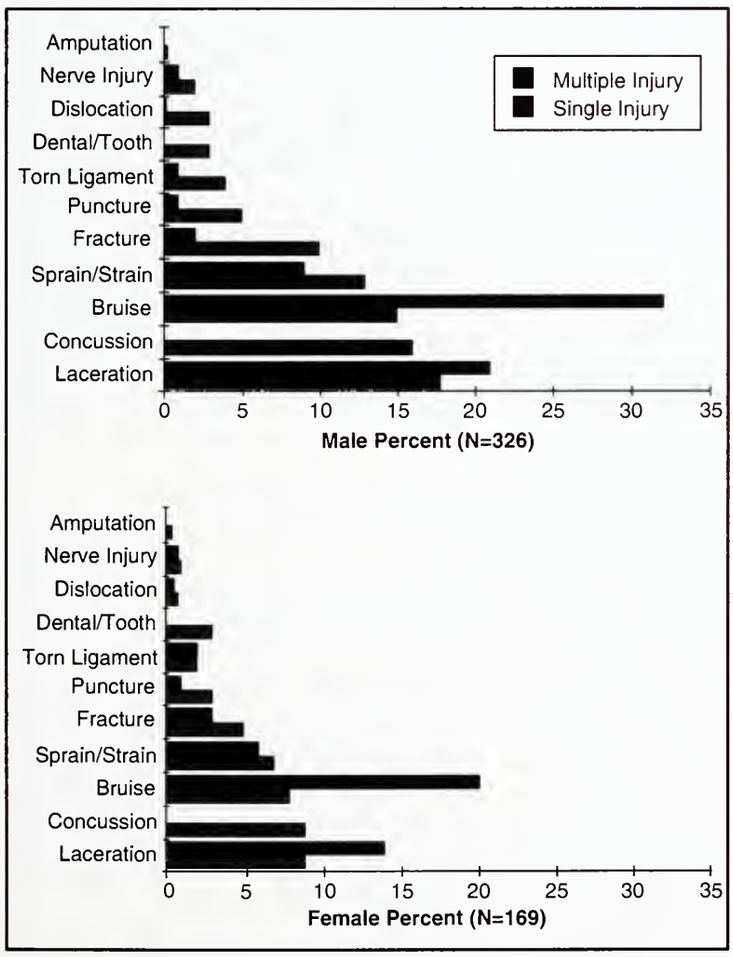

Figure 2–Incidence of single and multiple injuries, by injury type and gender, Minnesota bicycle-motor vehicle collisions (1984).

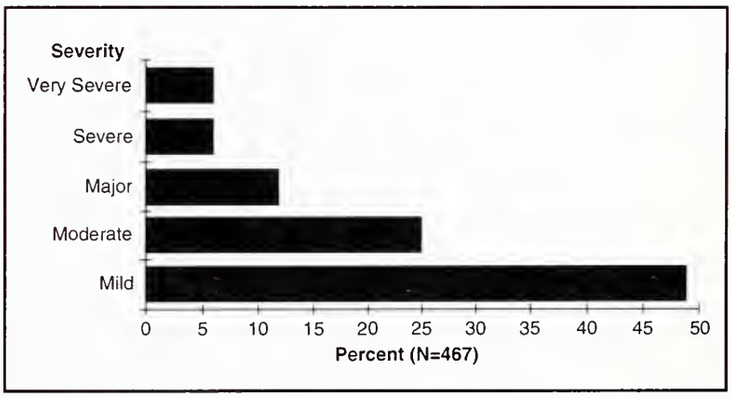

Figure 3–Severity of injuries, Minnesota bicycle-motor vehicle collisions (1984). **Very Severe:** a permanent disabling problem such as paralysis, amputation, hearing loss, vision problem, limited range of movement of leg/arm, etc., or a permanent problem of any kind. **Severe:** unable to return to regular activity for two months or more but have either recovered or expected to recover fully. **Major:** unable to return to regular activity for more than three weeks but in less than two months. **Moderate:** able to return to regular activity within one to three weeks. **Mild:** able to return to regular activity in less than one week.

this group surpassed the increase from any other type of motor vehicle-related crash in any age group. Although it is believed that this phenomenon is related to increased bicycle use by adults, there are no adequate denominator data to confirm this.

The head, neck, and face, as well as the upper and lower extremities, are the anatomical sites most frequently associated with bicycle injuries.[4,7,10-14] Definitions of injury and methods of identifying diagnoses vary from one study to another. The primary injury types reported in this study are generally consistent with those reported by other researchers.[3,11-14,18] An exception to this is the finding that 23% of the respondents in the current study reported concussions due to their collisions. Other studies,[13,16,19,20] which have reported concussions occurring in 3% to 4% of the subjects, examined both bicycle-motor vehicle and single vehicle events. A study of all injured bicyclists in Switzerland in 1984 revealed that 26% were treated for craniocerebral trauma.[21] It seems plausible that the higher incidence of concussion reported in the current study reflects the greater risk of severe injuries during collisions with motor vehicles.

Not only were 45% of the individuals in this study confined for a period of time as a result of the injuries sustained in the collisions, but 26% had persistent discomfort and/or other unresolved (including permanent) conditions that interfered with their regular activities *at least two years* following the event.

This study and other research efforts have consistently demonstrated higher proportions of bicycle injuries from all causes throughout the summer months, probably reflecting higher rates of use and more rider miles per bicycle during this period;[3,12,22] however, relevant denominator data are not available to confirm this. Of the collisions reported by respondents in this study, 34% occurred between 3 p.m. and 6 p.m. Other studies also note higher rates of injuries during the latter part of the day.[12] This may reflect increased risk due to greater bike use and/or poorer visibility secondary to diminishing or low-angle light.

As in this study, other researchers have noted that characteristics of the roadway, especially of the road surface, appear to contribute to collision episodes.[11-14,19,22] In a study of injuries among children, Lennon et al.[23] observed that the majority of bicycle-motor vehicle collisions occurred on straight roads. Approximately half of these events occurred at intersections, 82% of which were uncontrolled. Nixon et al.[24] also found that 48% of reported collisions occurred at intersections in their study of childhood bicycle injuries. Police reports from the current study indicated that 59% of the collisions occurred at intersections, 17% of which lacked traffic control devices.

In a previous study of factors associated with bicycle-motor vehicle collisions, bicyclists were struck by left-turning motor vehicles in 28% of reported cases and were struck from behind by motor vehicles in an additional 28%. Other authors have observed similar patterns of collisions between motorcycles and other motor vehicles.[25] In the current study, cyclists were hit from behind in 42% of the cases and struck by left-turning vehicles in 14% of the cases.

Intersections, particularly uncontrolled intersections, present a hazardous environment to the cyclist. The vulnerability of bicyclists to left-turning motor vehicles and vehicles overtaking them from the rear suggests certain factors may place cyclists at greater risk of collision and injury. In particular, it is quite likely that the bicyclist may initially be unnoticed by the motorist due to perceptual limitations.[26] Enhanced visibility, including the application of continuous lighting to both the rider and to the bicycle, would provide the biker an extra measure of protection in a decidedly unfriendly environment.[26,27] Most important, separated, well-maintained pathways and controlled intersections, where feasible, could significantly reduce collisions. Finally, the literature suggests that required use of bicycle helmets would effectively reduce the frequency and severity of head injuries sustained in such collisions.[26,28,29] Savings associated with bicycle helmet use has been estimated between $183 million and $284 million for the United States.[30]

Summary

In summary, the following interventions are recommended:

- increase the availability of separate bicycle lanes;
- implement legislation to provide for the sale of bicycle helmets with the purchase and registration of bicycles for all ages;
- require and enforce the use of bicycle lights and reflective vests; and
- initiate surveillance to identify areas where collisions are most likely to occur, e.g., intersections.

This study represents an effort to characterize the injuries sustained in bicycle-motor vehicle collisions and the persistence of problems resulting from these injuries, as well as to identify some of the roadway and other environmental conditions associated with collisions. Inasmuch as 26% of those participating in the study reported unresolved health problems, including paralysis, paresthesias, memory loss, and residual pain fully two years post-injury, it is evident that bicycle-motor vehicle collisions demand further investigation. The total costs incurred from such events are measured not only in terms of physical trauma to individual cyclists, but also represent a significant public health problem in terms of broader economic and social costs borne by the larger community. MM

Acknowledgments

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Susan Goodwin Gerberich is an associate professor and director of the Regional Injury Prevention Research

Center at the University of Minnesota School of Public Health. At the time of this study, Mark Dudzik was a student in the Division of Environmental and Occupational Health, University of Minnesota School of Public Health; he currently is director of anthropology, Burnett County Historical Society, Siren, Wisconsin. David Parker is an epidemiologist at the Minnesota Department of Health, Chronic Disease and Environmental Epidemiology.

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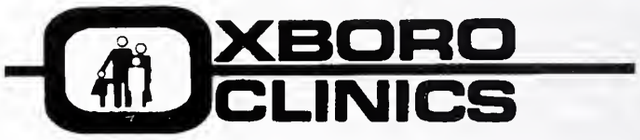

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The Monitor

News For Minnesota Physicians

Announcements

Minnesota Residents Receive Awards

The MMA Resident Physicians Section presented awards to Mark Holub, M.D., and Terry Schneekloth, M.D., honoring them for outstanding leadership in the AMA and the MMA Resident Physicians Section. The awards were presented at the MMA Resident Physicians Section meeting in Rochester on February 19, 1994.

• • •

Dr. Robert Fisch's Art Exhibition Opens

An art exhibition by MMA member Robert O. Fisch, M.D., opens April 7 at the Frederick R. Weisman Art Museum at the University of Minnesota and continues through June 17, 1994. This exhibition, "Light from the Yellow Star: A Lesson of Love from the Holocaust," features a series of 17 gouaches and accompanying prose created by Fisch, a professor of pediatrics at the University of Minnesota. A frequent contributor of illustrations to *Minnesota Medicine*, Fisch designed the cover and wrote an accompanying article for the October 1989 *Minnesota Medicine* focusing on medical-ethical issues raised by the Holocaust.

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Call MMA's Fax on Demand Hotline

Call 800-DIAL-MMA and ask for current information about MMA activities to be sent directly to your fax machine. The MMA's recorded message will tell you what information is currently available and how you can obtain it.

Legislators Compromise on 'Any Willing Allied Provider'

Feuding lawmakers Sen. Linda Berglin, DFL-Minneapolis, and Sen. Duane Benson, IR-Lanesboro, have mended fences at least temporarily and reached a compromise regarding a proposal that community integrated service networks (CISNs) must establish "extended networks" to include any willing allied health care provider. At the MinnesotaCare bill's first hearing in the Senate Health Care Committee March 9, this issue threatened to split the bipartisan Legislative Oversight Commission on Health Care (LOC) along party lines. Benson and the other IR member of the LOC, Sen. Joanne Benson of St. Cloud, removed their names from the bill in protest after Berglin offered an amendment that would have required CISNs to allow enrollees to go to allied health care providers in an "extended network" without paying extra money.

The Minnesota Medical Association opposed this amendment arguing that CISNs could not compete with HMOs if they had to provide this expensive option. As an alternative, the MMA offered an amendment that would have required CISNs to offer an option allowing enrollees access to any health care provider, including allied providers, at a higher cost. This amendment was defeated.

Now, according to Berglin, LOC members agree on a new amendment to the Senate MinnesotaCare bill that would address opponents' concerns. This amendment would require each CISN to establish an expanded network of "allied independent health providers" in addition to a preferred network and to accept any allied provider who met the CISN's credentialing standards and agreed to comply with its managed care protocols. The compromise allows CISNs to establish separate premium rates and cost-sharing requirements for the expanded network and to use the following managed care protocols:

- require a referral from the CISN;
- limit the number and length of visits allowed by each referral to the same extent as they would be limited to a provider in the preferred network;
- require ongoing CISN management and review of care.

Allied providers in the extended network would be paid at the same rate as those in the preferred network. It is not clear how this would apply to a CISN that paid its providers on a capitated basis.

This amendment would affect audiologists, chiropractors, dietitians, home health care providers, marriage and family therapists, nurse practitioners, advanced practice nurses, occupational therapists, optometrists, opticians, outpatient chemical dependency counselors, pharmacists, physical therapists, podiatrists, licensed consulting psychologists, psychological practitioners, licensed social workers, and speech therapists. It would not apply to staff-model CISNs.

When the Senate Commerce Committee considered the bill and

Compromise continued on page 35

Test Your Cultural Awareness

Recently, a Hmong patient who lives in the Twin Cities told this story to a member of the Minnesota Medical Association Committee on Minority Affairs.

"On December 7, 1993, my husband and I took our daughter to see a specialist, Dr. X, to have her ears checked. When the specialist read the referral with my family physician's name on it, he said, 'I don't know this doctor.' Then he checked my daughter's ears and told us that she needed to have tubes put in her ears. My husband told the doctor that he would like to discuss this with his parents first. The doctor asked, 'Is your father a doctor?' My husband said no. The doctor said, 'There, you see, he is not educated enough to know these things.'

"I didn't like the way the doctor spoke to us. I think our education should not matter, and that we should be entitled to our own opinions. I will not go back to this doctor again. I would like my family to be treated with respect."

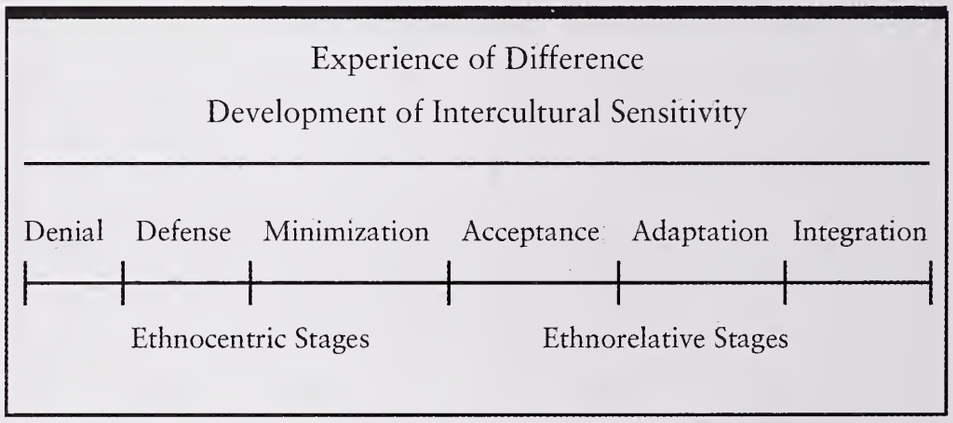
Thomas Day, M.D., past chair of the MMA Committee on Minority Affairs, offers some insights into why this impasse occurred. In the Hmong culture, a decision like this would be made by the clan leader, not by the individual. "We should acknowledge that some of our patients may have a different definition of the role of the physician and the patient, and maybe even a different definition of disease and health. For a Hmong family, the strength and welfare of the clan is more important than that of the individual. This is the exact opposite of the way most people in the United States think. This difference in outlook leads to different ways of making decisions. The parents have to check out an important medical decision with the family and clan leader."

This incident illustrates just one of the cultural factors that can influence the interaction between physician and patient. There are other examples in the Hmong culture. Patting a child on the head would be disrespectful; the head is considered sacred. Removing a string bracelet to start an intravenous line would cause great distress. This bracelet, given to babies at birth, is thought to connect them with their ancesters and to keep their souls from escaping their bodies.

With such extreme differences in cultural outlook, how can you avoid any mistakes? You probably can't, according to Day. The most well intentioned person could do something that would be disrespectful in the context of another culture. But you can be aware that there *are* differences, even if you don't know what all of them are. You can be open and accepting. You can be willing to ask your patients if they understand and agree with your course of treatment.

Day also suggests that you become aware of body language. If you see a patient stiffen up, or their eyes glaze over, ask if something's wrong. A good interpreter can be an enormous help, not just in translating the words, but in putting your ideas into the patient's cultural context. But finally, in order for the encounter to be successful, the patient has to meet the physician halfway. It takes two to communicate. You can only do your part. • • • • •

Where Is Dr. X on the Cultural Awareness Scale? Where Are You?



The Rural Clinician Quarterly recently printed an ethnocentric scale, developed by M.H. Bennet, that gauges how a person reacts to cultural differences.

Ethnocentric Stages

Denial—hasn't encountered or noticed differences, has a parochial world view.

Defense—stereotypes others and assumes superiority of own culture.

Minimization—sees cultural differences as trivial, considers similarities more important.

Ethnorelative Stages

Acceptance—accepts behavior differences and the underlying cultural value differences.

Adaptation—adapts to differences, shows empathy.

Integration—can actually construe self in various cultural ways.

Compromise *continued from page 33*

compromise, A. Stuart Hanson, M.D., urged legislators to adopt instead the MMA amendment that would require CISNs to offer a more expensive option allowing enrollees to see *any* health care provider, including any allied provider. Unlike the Berglin/Benson compromise amendment, this would not require the establishment of another network. Berglin opposes the inclusion of physicians in the "any willing provider" requirement because she claims the higher cost of their services would make it too expensive.

Hanson also told the Senate Commerce Committee that the MMA strongly supports the MinnesotaCare bill's commitment to achieve health care coverage for all Minnesotans by July 1, 1997, as well as the CISN net worth requirements and three-year phase-in period.

The Senate Commerce Committee accepted the LOC compromise language in place of the Berglin amendment adopted by the Senate Health Care Committee and passed the MinnesotaCare bill.

Rep. Lee Greenfield, DFL-Minneapolis, tried to attach the LOC compromise amendment to the House version of the bill. Testifying before the House Financial Institutions and Insurance Committee, Anthony Jaspers, M.D., stated that the MMA strongly opposes a requirement for CISNs to offer an extended network because it will result in added costs that will prevent the CISN from being able to compete with existing health plans and ERISA products. After lengthy debate, Rep. Dave Gruenes, IR-St. Cloud, proposed changing the wording of the amendment from "shall" to "may," making it optional for CISNs to offer an extended network of allied health care providers. This change was accepted, and, after hours of hearings, the amended bill passed the House Financial Institutions and Insurance Committee. • • • • •

Submit Nominations for Minority Service Award

• • • • • THE MMA INVITES YOU TO submit nominations for the new MMA Award to a Physician for Meritorious Service to Minority Populations, which will be presented at the MMA Annual Meeting whenever an appropriate candidate is identified.

The nominee must be a doctor of medicine or of osteopathy licensed in Minnesota who has provided "a significant medical service to a minority patient population resulting in improved medical care for the patients."

Nominations, **due May 1**, must include a complete description of the medical service provided by the nominee, and must be accompanied by endorsements from each of the following persons:

- a professional colleague of the nominee,
- a community leader knowledgeable about the contributions of the nominee,
- a patient who is a member of the minority patient population receiving medical care from the nominee.

Submit nominations to Dennis Hines, M.D., chair of the MMA Committee on Minority Affairs, Minnesota Medical Association, Suite 300, 3433 Broadway Street NE, Minneapolis, MN 55413-1761.

LEGISLATIVE NEWS

MMA Supports Provider Survey

The Minnesota Medical Association supports the Minnesota Department of Health's introduction of an amendment to the MinnesotaCare bill that would require provider surveys as well as patient satisfaction surveys. The provider survey would gather information on "opportunities and barriers to the provision of quality, cost-effective health care" such as administrative barriers, time spent obtaining permission for treatment, and latitude to order tests, pharmaceuticals, and referrals to specialty providers.

Seat Belt Bill Introduced

The MMA strongly supports a bill S.F. 1726/H.F. 2005, introduced by Minneapolis DFLers Sen. Linda Berglin and Rep. Lee Greenfield, which would allow police officers to stop drivers for not wearing a seat belt. Currently, failure to use a seat belt is a secondary offense, punishable only if the driver is stopped for some other violation.

No Smoking in Common Areas Bill Progresses

An amendment to the Clean Indoor Air Act banning smoking in common areas, H.F. 423-Lourey, has passed the House, and its companion bill, S.F. 0372-Merriam, is waiting to be heard on the floor of the Senate. The MMA has strongly supported and testified in favor of this bill to protect the public from the dangers of second-hand smoke.

LEGISLATIVE NEWS

MMA Amendments Are on BMP Diversion Program Bill

The Senate Health Care Committee has accepted the MMA amendments to the diversion program bill, S.F. 1849-Piper/H.F. 2120-Kelley, drafted by the Board of Medical Practice (BMP). Now that the bill has been amended to protect physicians' due process rights, the MMA supports it.

The BMP bill would allow two or more health licensing boards to create a joint program to evaluate, treat, and monitor licensed health care providers who suffer from mental, physical, or psychological problems. This program would operate outside the boards' disciplinary process.

The MMA, working with a coalition of associations representing nurses, dentists, chiropractors, pharmacists, optometrists, podiatrists, and psychologists, successfully negotiated with the licensing boards and with legislators to improve the bill with a number of amendments, including those summarized below.

In a major improvement, rule making would now be required so that potential problems regarding due process rights could be solved. Rules would be developed by an advisory committee consisting of representatives of each of the regulated health professions. The MMA is specifically named as a participant in the rule-making process.

The diversion program would now be forbidden to send information about a participant to the BMP unless the program was reporting the participant for some reason, such as non-compliance. Reports to the program would be classified as "confidential and privileged" so they would not be accessible to anyone outside the program. Monitoring data would be classified as "private," which means it would be accessible only to its subject and to government officials whose duties reasonably require access. Immunity would now be offered only for "good faith" reporting.

The Senate Health Care Committee passed out the amended bill March 16, and it now goes to the Governmental Operations and Reform Committee. The MMA amendments have also been added to the House version of the bill, which is waiting to be heard in the Health and Human Services Committee.

The amendments to the BMP bill are a significant victory for the MMA, but the fight isn't over. The House Health and Human Services Committee will also consider a proposal by Rep. Steve Kelley, DFL-Hopkins, that could lead to a "super board," a unified licensing entity that would regulate all health-related professions. The MMA opposes this proposal, which is inconsistent with the physician tradition of self-regulation.

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Administrative Simplification Bill Raises Data Privacy Issues

Sen. Linda Berglin, DFL-Minneapolis, has pulled Article 9, regarding administrative simplification, out of the MinnesotaCare bill and introduced it as a separate bill in order to speed along the legislative process.

This bill sets forth standards for electronic data interchange. It would create the Minnesota Center for Health Care Electronic Data Interchange, provide standards for the Minnesota health care identification card, establish standard billing forms, and use Social Security numbers as identifiers for both patients and providers.

Berglin tried to whisk this bill through the Senate Data Privacy Subcommittee on March 17, but the MMA and others objected to several provisions in the bill. In testimony before the subcommittee, MMA lobbyist Ted Thompson said, "The issues in Article 9 are too important and too complex to rush through this committee. Nothing is more important to the individual patient and provider than retaining the confidentiality of one's health record." He warned that even with the required encryption, abuses are possible.

The MMA follows AMA policy opposing the use of Social Security numbers to identify patients and providers and advocating a standard identifier. MMA attorneys are exploring the possibility that federal law may actually prohibit the state from using Social Security numbers as identifiers. The other major objection to this bill is that despite the sensitive nature of maintaining privacy in an electronic data interchange system, it doesn't provide for sufficient rule making.

Thompson told legislators that strict civil and criminal penalties should be imposed for the misuse of health data, and there should be absolutely no immunity for the government or its employees for the misuse of health data.

The Senate Data Privacy Subcommittee is still considering this bill.

Return MDH Survey

Physician clinics with Medical Assistance provider numbers beginning with 21 received a survey from the Department of Health requesting information on revenues and expenditures. All surveys were to be submitted to the department by February 15, 1994. Extensions were available. If you have not submitted your survey or requested an extension, please call Jerry Dalnes at 612/282-6312 as soon as possible to avoid penalties.

Viewpoint

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Gail L. Gamble, M.D.
Chair, MMA Board of Trustees

Reform Must Be a Shared Responsibility

Will health system reform achieve its goal? The answer depends on whether the Legislature is willing to pass controversial laws requiring all Minnesotans to share the responsibility for achieving universal health care coverage.

There are three major components of health system reform. Taken together, they make health system reform a shared responsibility. Physicians, employers, consumers, businesses, insurance companies, and individuals must all shoulder part of the burden.

The first component of reform is the integrated service network (ISN)/regulated all-payer option (RAPO) plan that focuses on controlling health care costs. This proposal requires us to change the way we practice medicine. We must either join networks or participate in a regulated all-payer option. In the best interests of our patients, we are willing to do our part. But the other players must join us if all Minnesotans are to be guaranteed affordable health care.

The second component of reform is the Minnesota Health Care Commission's plan for achieving universal health care coverage. This proposal calls on insurance companies to offer coverage to everyone, to eliminate pre-existing condition exclusions, charge everyone the same premium for the same plan, and allow people to move their insurance coverage between companies without restrictions. Everyone would be required to have insurance for basic health care services.

Since not everyone will be able to afford to pay the premiums, the state will have to fund subsidies. This will require the Legislature to ask all Minnesotans to help pay the bill. Despite the political difficulty of enacting a broad-based tax, reliable funding must be part of the plan. The reason for instituting major changes in a health care system that serves most Minnesotans well is to make sure that everyone, including Minnesota's 370,000 uninsured, receives appropriate health care. This will cost money.

The third component of reform is the commission's Consumer Incentives and Prevention Plan, which creates incentives for the people of Minnesota to lead healthier lives. It would increase the cigarette tax by 40 cents per year for the next five years; increase the alcohol tax; require people who ride motorcycles, snowmobiles, and all-terrain vehicles to wear helmets; allow officers to stop drivers who don't wear seat belts and increase the fine from $25 to $100. Money would be used to fund MinnesotaCare and disease prevention programs.

From a rational standpoint, a proposal to improve health and safety while at the same time funding coverage for the uninsured should be as easy to pass as an endorsement for Mom's apple pie. From a political standpoint, it faces stiff opposition.

To prepare for the expected battle, the Minnesota Medical Association spearheaded the formation of the Tobacco Tax Coalition to marshal support for the increase in the cigarette tax. In addition to improving our patients' health, this proposal would help pay the astronomical cost of treating smoking-related illness. By causing disease and premature death, tobacco costs Minnesota nearly a billion dollars a year in direct health care costs and in lost income. In support of the cigarette tax, Tom Swain, commission chair, cites the example of trucks that pay extra taxes because they cause more wear and tear on the highway. The same analogy could be used to support the commission's helmet and seat belt proposals. The commission's Consumer Incentives and Prevention Plan cites the following statistics from the Minnesota Department of Public Safety: People who are not wearing seat belts at the time of a crash are nearly five times as likely to be killed and more than twice as likely to be seriously injured. In Minnesota between 1988 and 1991, the risk of dying as a result of a motorcycle crash was 2.3 times greater for non-helmeted riders.

The benefits to society of the consumer incentives proposal are undeniable. But as *The Monitor* goes to press, the 1994 MinnesotaCare bill in the Senate includes the ISN/RAPO plan and most of the universal coverage plan, but omits the consumer incentives proposals and postpones a decision on funding until next year, when a report would be due from the commission.

The MMA will continue to urge legislators to treat health system reform as a shared responsibility. Unless we enact all three components, health system reform efforts could end up causing massive changes in our delivery system with no real benefits. All Minnesotans must pull together to achieve the goal of health care coverage for everyone. • • • • •

MINNESOTACARE NEWS

MHA Proposes Health Care Co-ops

Into the reform stew of ISNs, CISNS, and RAPO, the Minnesota Hospital Association (MHA) has tossed a new ingredient—health care co-ops. This new concept would not replace the existing health care reform proposal but would be added to it.

The MHA proposal, called the "Minnesota Health Care Cooperative Act," is based on an idea more familiar to rural than urban Minnesotans. Nearly 400 co-ops provide Minnesotans with services such as electricity, telephones, food, and farm products. Most of these co-ops are in Greater Minnesota.

Co-ops are organized as corporations, but each member has one vote regardless of the number of shares owned. A member's share in the co-op's gains and responsibility for covering its losses depends on the number of shares owned. Each member stays independent and keeps its own identity.

The proposal would create two types of cooperatives: health network co-ops (the buyers) and health provider co-ops (the sellers).

1) Health Network Co-ops

Employers, individuals, and local units of government could organize as a health network co-op to buy health care coverage for their members. As co-op members, small businesses would gain leverage to negotiate affordable health care coverage for their employees. Each member would have one vote and would help elect a board of directors to manage the co-op.

The co-op would choose whether to be licensed as an HMO or as a mutual insurance company offering a fee-for-service plan to its members. Either way, the co-op would have to maintain $1.5 million or two months' claims in net worth and would have to meet a deposit requirement of $300,000 phased in over a two-year period. If the co-op, a contributing member of the Minnesota Comprehensive Health Association (MCHA), became insolvent, enrollees would be able to receive MCHA coverage.

Using the accredited capitated provider (ACP) concept, a co-op could reduce its net worth requirement down to $1 million. This would allow health care providers to become stakeholders in the local co-op. The ACP member would agree to provide health care services for three months if the co-op became insolvent and its other assets were depleted. The co-op could issue preferred stock to an ACP member.

2) Health Provider Co-ops

Independent providers such as physicians, clinics, or hospitals could organize as a co-op to sell their services to large buyers such as ISNs, HMOs, and health care network cooperatives. The MHA proposal would give antitrust protection for sharing services and technology among co-op members. The provider co-ops would contract to provide services to purchasers on a capitated or other risk-sharing basis. Because a health provider co-op would not be an insurance company, no solvency or reserve standards would apply. Government-owned facilities, private clinics, and nonprofit providers could work together in a co-op without mingling their assets or losing their own identity. Local clinics could form cooperatives with hospitals, and rural provider co-ops could include tertiary urban hospitals.

Commission Recommends Voluntary Distribution Planning

The Minnesota Health Care Commission has drafted an amendment to the MinnesotaCare bill that would set up a voluntary process for planning for the distribution of health care technology, facilities, and functions. Consumers, employers, and other group purchasers, providers, health plan companies, and the health care technology industry would be included in the process.

The draft amendment was developed by a subcommittee chaired by Ray Christensen, M.D. The subcommittee was asked to consider the role the Health Technology Advisory Committee should play in planning distribution of technology. The commission approved the subcommittee's draft amendment at its March 15 meeting.

This amendment would allow the commission to create an open, public forum to reach consensus on whether a plan for distribution is needed for a particular technology, facility, or function. If the forum decides a plan is needed, the forum would reach consensus on a plan that would lead to appropriate distribution within the region and the state. Participation in the forums would be voluntary, and the recommended plans developed would not be binding on any person or organization. The commissioner of helath could consider the distribution plans as part of deliberations on antitrust exceptions, but she would not be bound by them. The commission could appoint advisory committees to facilitate discussion and planning and could request that regional coordinating boards serve as, or convene, regional public forums.

ANNOUNCEMENTS

Physicians Needed for Breast Cancer Diagnoses

The 1994 Race for the Cure needs physicians, especially those in Greater Minnesota, to help provide diagnostic services for low-income and uninsured women who have had abnormal results in their breast screening exams.

The Minnesota Medical Association supports the Race for the Cure and encourages physicians to participate. This program provides matching funds to cover half the charge for diagnostic services and asks participating providers to donate the other half of their charges. Providers may donate in-kind services or funds.

Patients are referred to Race for the Cure from the Minnesota Breast and Cervical Cancer Control Program, a federally funded cancer screening program operating in 140 Minnesota hospitals and clinics to provide free mammograms and breast exams to low-income women. For women whose screening results are abnormal, Race for the Cure covers breast biopsies, surgical consults, ultrasounds, and other diagnostic care. About 75 women have received diagnostic services through Race for the Cure since June 1993. Race for the Cure services are available through contributing providers in the Twin Cities, but providers are needed in Greater Minnesota so women can be served in their own community.

Race for the Cure began in 1983 as a project of the Susan G. Komen Breast Cancer Foundation in Dallas. Since then it has grown from one local race to a national series of 33 races with over 125,000 participants. Over 2,000 people participated in the first Twin Cities Race for the Cure in 1993. The second annual Twin Cities race will be held on Mother's Day, May 8, 1994.

If you would be willing to contribute diagnostic services to Race for the Cure, or would like further information, call Mark Schoenbaum at the Minnesota Department of Health, 612/627-5464.

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MPHA Meeting Will Consider Role of Public Health

The Minnesota Public Health Association/School of Public Health Alumni Society encourages MMA members to attend its Annual Meeting April 21 to 22 at the Ramada Inn in Arden Hills. The theme of the meeting will be the changing role of public health in a reformed health care environment. For more information, contact Deb Hendricks at 612/266-2421.

What Do You Think of Changing the Annual Meeting Schedule in 1995?

• • • • • Speaker of the Minnesota Medical Association House of Delegates Barbara Yawn, M.D., would like to hear MMA members' reactions to proposed changes in the MMA Annual Meeting schedule beginning in 1995. A special committee appointed to evaluate the current structure and purpose of the annual meeting recommends the following changes:.

- Expand the 1995 Annual Meeting to two and a half days.
- Convene Session I of the House of Delegates at 1 p.m. on Wednesday afternoon rather than on Thursday morning.
- Schedule the AMA open forum and the MinnesotaCare open forum later on Wednesday afternoon.
- Schedule open testimony in two reference committees on Thursday morning and in the other three reference committees on Thursday afternoon rather than holding all reference committee hearings at the same time.
- Convene Session II of the House of Delegates at the usual time on Friday morning.

The purpose of expanding the Annual Meeting is to allow more time for delegates to learn about the issues and share information before they cast their votes. Scheduling educational forums such as the AMA and MinnesotaCare open forums after the first session of the House of Delegates will increase attendance. Holding some reference committee hearings in the morning and others in the afternoon will allow delegates to attend several hearings and make it easier for them to testify before more than one committee.

If you would like to comment on the proposed changes, write to Barbara Yawn, M.D., at the Minnesota Medical Association, Suite 300, 3433 Broadway Street NE, Minneapolis, MN 55413-1761.

ANNOUNCEMENTS

First Quarter Provider Tax Payments Are Due

April 15, 1994, marks the first deadline for submission of estimated provider tax payments. If your expected tax is less than $30,000 for each individual quarter, you can choose to pay your tax for that quarter by electronic transfer or by filling out and mailing a MinnesotaCare deposit form to the Minnesota Department of Revenue.

If the tax you expect to owe for any quarter in 1994 is greater than $30,000, you must pay the tax for the remaining quarters of the year by electronic transfer.

Future payment deadlines are July 15, 1994; October 17, 1994; and January 17, 1995. The annual return for health care providers will be due March 15, 1995.

For more information, contact the Minnesota Department of Revenue, MinnesotaCare Tax Division, at 612/282-5533 or 800/657-3886.

MMA Peer Review Brochure Is Available

A brochure describing the MMA's Peer Review Consultation service is now available. This new MMA service is designed for hospitals, clinics, and other organizations that may need peer review by an impartial third party and has been tailored to meet state and federal regulations. To receive your Peer Review Consultation Brochure, call Pat Hanson at the MMA, 612/378-1875 or 800/999-1875.

SEMINARS

MMA to Offer Media and Spokesperson Training

The MMA will offer media and spokesperson training Saturday, April 30, 9 a.m. to 1 p.m. The program will include the following topics:

- speech structure;
- impromptu speaking;
- interview skills;
- television interviews;
- self-evaluations.

The program will be held at the MMA office building on Broadway Street and Industrial Boulevard in Minneapolis. The registration fee is $25. To register, send a check to: Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, Attention: Mark Vukelich. For more information, call Mark Vukelich 612/378-1875 or 800/999-1875. The program will be limited to the first 15 registrants.

Breast Screening Interactive Teleconference

A three-hour symposium entitled "Advances in Screening, Diagnosis, and Treatment of Breast Cancer" will be broadcast by Medical Education Network and made available via satellite to hospitals, medical facilities, government agencies, and managed care groups throughout the country. The teleconference will be broadcast Monday, April 11 from 10 a.m. to 1 p.m.

The teleconference will include presentations by prominent oncology experts and a discussion of the controversy surrounding mammograms for women of various age groups. Viewers may call a toll-free number to question panel members. For information about the nearest medical facility airing the broadcast, call 800/572-3953.

Tough Decisions—High Tech Medicine: Who Decides? Who Pays? Who Benefits?

Memorial Blood Centers of Minnesota will sponsor a one-day conference May 2 at the Radisson South in Bloomington. Rep. Patricia Schroeder, D-Colo., is the keynote speaker. Autologous bone marrow transplantation as a treatment for breast cancer will be used as a case study. The conference is co-sponsored by Baxter and Medical Alley. For more information, call Memorial Blood Centers of Minnesota at 612/871-3300.

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Communicating DNR Orders in Non-Hospital Settings

The MMA has developed guidelines for communicating DNR orders to ambulance service providers, and communities should use these guidelines to cooperatively develop protocols.

Barbara J. Blumer, J.D.

The Minnesota Medical Association adopted Emergency Resuscitation Guidelines in 1993 for all non-hospital settings. These guidelines recommend a standardized form* to be used throughout the state to communicate "do-not-resuscitate" (DNR) orders to ambulance service providers for patients in nursing homes and residential or program settings. Various groups have developed forms for this purpose, and the MMA recommends standardization to eliminate confusion. The continuing shift in health care away from institutional settings to supported residential and program settings increases the likelihood of cardiopulmonary arrests occurring in the community. More elderly and chronically ill patients are participating in programs designed to keep them out of hospitals and nursing homes, and patients are typically discharged earlier from hospitals or undergo outpatient procedures. Community residents wishing to decline CPR in the event of a cardiopulmonary arrest need a clear mechanism for communicating their decisions to ambulance personnel.

The increasing use of advance directives for health care, such as living wills and health care powers of attorney, reflects the public's conviction that choices about health care should be honored even after a person loses the capacity to communicate decisions personally. Advance directives already can be implemented through physician orders in hospitals and nursing homes, but a clear mechanism is needed in the community setting as well.

Elderly patients who need care have many options besides nursing homes, and implementation of the MMA guidelines will vary with different settings. Many elderly are choosing to live in the community with supportive services provided in a variety of ways—by a spouse, through a home-care provider, in a congregate setting with minimal services, in an assisted-living setting with relatively intensive services, or in an adult foster-care home with 24-hour staff supervision. Many others attend adult day-care programs (which do not typically have regular nursing staff) while living at home. Most settings do not have persons trained to evaluate and handle emergencies, and, hence, 911 will be called in most situations.

This article suggests issues for communities to discuss when developing local protocols under the MMA guidelines. It also reviews practical issues physicians and other service providers should consider when discussing and implementing community DNR plans with patients and clients.

Community Protocol Development

Ambulance personnel operate under the authority of the ambulance service medical director and are bound by standing orders, which typically require initiation of CPR in all medically indicated situations, regardless of what people on the scene request. In the past, ambulance personnel have typically not been able to recognize the authority of a DNR order written by a physician on the charts of a nursing home or home-care provider. Ambulance personnel cannot take the time to evaluate the validity of a DNR order in a non-standard format or to evaluate whether they can take direction from a patient's appointed agent under a health care power of attorney or living will.

Communities must address this issue cooperatively. With our aging population and more elderly living at home, non-hospital service providers are ready to join forces with local medical societies and ambulance service providers to develop workable and consistent systems for their communities. A community task

* Copies of the standardized DNR form are available from the MMA; call 612/378-1875 or 800/999-1875. The new DNR guidelines, "Recommended 'Do Not Resuscitate' (DNR) Guidelines for Minnesota Emergency Medical Service Agencies, 1993" are based on previously adopted MMA guidelines, HD-R30-1990, and on similar 1992 Metro Emergency Physicians Committee guidelines. See also: Crimmins TJ. Communicating DNR orders to ambulance personnel. Minn Med 1991;74:33-5.

force should be established to consider this issue and should include representatives of the local medical society, the medical examiner, the ambulance providers, the nursing homes, senior and other housing providers, the licensed home-care agencies, the hospice service providers, the adult day-care providers, the adult foster-care providers, and the county public health department or other appropriate county representatives.

Identifying residential and program settings

The task force's first goal would be to identify all potential residential and program settings in which patients and clients with DNR orders might live or participate. This very important identification would allow the task force to explore and resolve considerations raised by representatives of each setting.

Developing completion guidelines

The second goal of the group would be to adopt a common DNR form along the lines of the recommended MMA form and to develop completion guidelines. The completion guidelines could specify that the form should be printed on only one color (making it clear that ambulance providers will not recognize forms on other colors), could clarify whether photocopies will be acceptable or whether multiple originals should be provided for different locations the patient frequents, could encourage or require additional patient identifying information to assist ambulance providers with proper identification, and could give advice or direction on other questions related to executing the form. Proper execution is critical for ambulance providers to accept a form, and the community should be provided with clear standards to follow.

Developing implementation procedures

The third goal of the group would be to develop implementation procedures applicable to each setting in which a DNR order may be communicated. These would include protocols concerning storage and display of the form for ready access by family, service staff, and ambulance personnel. The protocols should be clear and easily understood by non-medically trained family members and staff of home-care agencies and housing and adult day-care programs. They could also expand on the Recommended Actions component of the form itself, which recommends not calling 911 in the event of a cardiopulmonary arrest if a person has a DNR order. The protocols should recognize that non-medically trained families and program staff may be unable to assess whether a patient is having a cardiopulmonary arrest and, therefore, will call 911 in virtually every case, even if the recommended action for a DNR order is to refrain from calling 911.

> "In the past, ambulance personnel have typically not been able to recognize the authority of a DNR order."

Distributing forms and providing education

The fourth goal of the group would be to distribute the community forms, completion guidelines, and implementation procedures throughout the community and to provide ongoing education. For example, education may be through home health nursing, ambulance personnel, or community health care.

Physicians' Responsibilities

It is the physician's responsibility to initiate discussion with patients and families about a community DNR order. Hospital discharges to a nursing home or the community and the patient's transmittal of a living will or health care power of attorney provide ideal opportunities for this discussion. DNR orders on nursing home or home health care charts should be accompanied by execution of a community DNR form. Physician designees are well-suited to conduct initial discussions, but the physician must actually execute the form before it will be valid.

The physician or physician designee will often obtain authorization from the patient directly. However, if the patient is incapable of giving authorization, the physician is responsible for obtaining authorization from the patient's proper legal representatives (a guardian or conservator of the person, a proxy under a living will, or an agent under a health care power of attorney) or from family members under appropriate circumstances. The physician should document discussions with the patient, legal representatives, and family members in the original record. The physician should determine who is the authorized signer on behalf of an incapacitated patient and should ensure that only that person executes the form.

The discussion with the patient, legal representative, or family members should include a clear description of the alternatives for emergency care. Most patients and family will not know, and will not be comfortable with, the recommendation to not call 911 in the event of a cardiopulmonary arrest under a community DNR order. Physicians must explain that families can still call 911 for assessment and support but should avoid CPR by displaying a properly executed community DNR form.

Completion of the Form

The DNR form should be filled out carefully and completely. Ambulance personnel will not recognize forms with errors or omissions, and a clearly expressed patient directive may be thwarted for want of a signature, date, or other information. All information must be legible and easily readable, and each item should be regarded as critical, especially the signature, address, and date.

Although a physician designee may be involved in the discussions leading up to the form's completion, the form is not valid unless a physician executes it. The form also requires the signature of a witness.

The recommended MMA form suggests providing optional identifying information, such as date of birth, sex, race, eye color, hair color, height, and weight. Providing this information will reassure ambulance personnel that the form applies to the person they have been summoned to assist. It may also be helpful to attach a picture of the patient, with the same name and identifying information written on the back. If ambulance personnel are not certain that they have the correct John Doe named in the form, they will perform CPR as medically indicated.

Although the MMA guidelines imply that photocopied forms can be adequate, executing multiple originals will eliminate questions about the form's validity. An original can then be kept at home, accompany the patient to adult day-care or on an outing, and be kept at the home of a frequently visited family member or friend. A community DNR form left at home does a person no good at a shopping mall or at church.

Issues for Patients, Families, and Service Providers

Most people assume that declining CPR through a living will and/or a health care power of attorney is sufficient to avoid CPR in all circumstances. The community should be made aware that such generalized desires must be transformed into physician orders that health care providers can recognize before they are truly effective.

Families and service providers receiving copies of living wills and health care powers of attorney should assist patients and clients in effectuating their desires through a community DNR order. Under the federal Patient Self Determination Act, all certified nursing homes, home-care agencies, and hospices must ask patients and clients for their advance directives, so these opportunities will arise routinely. The newly established home-care licensure rules require client service agreements to address when emergency medical services should not be summoned pursuant to directions in living wills, and the community DNR form is one component of that documentation.

The form itself should be displayed or stored in a readily accessible, standard location, and everyone involved with the patient should be aware of its location. Community display protocols should be rigorously followed, and family and service providers should check periodically to ensure that the form is still available.

A Troublesome Issue

Families often panic when an arrest occurs, and in their distress tell ambulance personnel to initiate CPR even if the family member had completed a DNR form and would have declined if able. The MMA guidelines state that the ambulance personnel should initiate CPR if family members request resuscitation. This family override is troublesome, justified only by emergency conditions in which ambulance personnel cannot be expected to judge the legal situation. Every effort must be made by physicians and service providers to educate the family about this issue in order to avoid panic and unwarranted requests to override the patient's wishes. Any person making the significant effort required to execute a community DNR order should be accorded respect for these wishes in the time of crisis, even if it distresses family members.

Conclusion

The 1993 MMA guidelines encourage local medical societies and ambulance service providers to establish protocols and forms so that ambulance personnel can recognize DNR orders in community settings. Publication of the form and guidelines is just the first step—local communities must take the final steps to establish working protocols. The development of those protocols should involve a wide spectrum of service providers to ensure that considerations unique to each are taken into consideration. MM

Barbara Blumer is an attorney with Orbovich & Gartner Chartered with offices in St. Paul and Eagan. She represents long-term care, senior housing, and home-care organizations.

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The Physician-Hospital Integration Sensation

The health care industry is rapidly consolidating, with many hospitals offering to buy clinics. Should you sell your practice? First of two parts.

Forrest Burke, J.D.

Dr. Bailey is an internist with Bedford Falls Family Physicians, a four-physician professional corporation located in Bedford Falls, Minnesota. For the past 10 years, Dr. Bailey's clinic has maintained a reasonably good working relationship with the administrative staff at the Bedford Falls Community Hospital. Although the financial performance of Dr. Bailey's clinic has declined somewhat over the last several years (due in large part to declining reimbursement levels and increasing practice overhead expense), Dr. Bailey has earned a comfortable living. After a recent medical staff meeting at the hospital, Ms. Potter, the hospital administrator, approached Dr. Bailey and said, "The hospital believes it needs to integrate with a group of high-quality physicians, and we feel your clinic would be a great fit. I would like to arrange a lunch with you next week to go over a proposal we have developed to purchase Bedford Falls Family Physicians and employ you and your colleagues."

Somewhat stunned, Dr. Bailey agrees to meet with Ms. Potter to discuss the proposal. On the way back to the clinic, Dr. Bailey is beset by a cascade of questions: What would it be like to work for the hospital? Could we form a separate clinic corporation with the hospital? Who would be my "boss"? How much is the clinic worth? Do we need to integrate with the hospital? What will my colleagues think?

The foregoing scenario is being played out with increasing frequency across Minnesota and throughout the United States. The health care industry is consolidating rapidly, and physicians in large cities and small towns alike are being presented with network and integration opportunities.

Many physicians have concluded that selling their practices to an affiliated hospital and becoming part of an "integrated delivery system" is in their best interest. Each transaction between a physician group and a hospital is different and should be tailored to suit a particular set of circumstances; however, certain legal and business issues should be considered in any case. Perhaps most important, physicians should take a hard look at the market and regulatory forces affecting their practices. If these forces are not compelling integration with the hospital, the physicians should not rush into an affiliation.

Before any physician group decides to integrate with a hospital, it should examine the relevant health care marketplace to determine whether integration is desirable or necessary to compete effectively. Many market regulatory forces drive physicians and hospitals to form networks or to integrate. In many Minnesota communities, the landscape has become populated with large employer-based or community-based coalitions of health care purchasers. These new health care purchasers are demanding that health care providers deliver cost-effective health care services of measurable quality, provide comprehensive care to large patient populations, and manage care and share risk. MinnesotaCare and the anticipated reforms flowing from federal health care initiatives will also ask health care providers to manage the health of large populations on a capitated basis and will require these providers to offer a seamless continuum of care. In addition, health care providers are under pressure to eradicate redundant services and to make the most efficient use of available health care resources.

The degree to which market and regulatory forces are driving a particular physician group toward integration may vary greatly depending upon the particular circumstances. The presence or lack of competing physician groups or other integrated providers in the marketplace will be one relevant factor. Physicians should also consider the variety of payer relationships they currently maintain and those that are maintained by the hospital or hospitals where they have medical staff privileges. If the current trend of payer affiliation with large provider systems continues, physician groups may find themselves being cut off from traditional sources of patients and revenue.

> "Before a physician group decides to integrate with a hospital, it should examine the marketplace to determine whether this is desirable."

If, after a review of the marketplace, the physician group concludes that some kind of formal affiliation with the hospital is an appropriate and desirable response to the shifting market and regulatory climate, then the physician group should begin to consider in greater detail the nature and structure of an integrated relationship.

Acquisition Structure

The sale of the medical practice must be considered carefully. If the medical practice is structured as a professional corporation and is subject to tax as a regular "C" corporation, a sale of the depreciated assets to the hospital will generate a taxable gain at the corporate level. This corporate tax will be followed by a tax at the shareholder level upon distribution of sale proceeds. The two levels of tax assessed on the sale proceeds significantly diminish the physician shareholders' financial gain. The measure of the tax at the corporate level will be the difference between the amount paid for the assets and the depreciated value of the assets as reflected on the corporation's books.

Because medical practices often own many significant depreciated assets, e.g., real estate, leasehold improvements, fixtures, and medical equipment, the amount of taxable gain at the corporate level can be substantial. In addition, if the practice sells its accounts receivable as part of the transaction, 100 percent of the payment for receivables will be taxable; however, this gain may be offset by compensation distributions to the physicians in the practice.

One way to avoid a corporate level tax on the sale of assets is to restructure the transaction as a sale of the professional corporation stock. Upon sale of the stock, each physician shareholder will be subject to tax on capital gains at a rate of 28 percent. A stock sale may be somewhat more difficult to negotiate for two reasons. First, the stock purchaser automatically assumes all the corporation's liabilities. In an asset sale, the buyer may specify the liabilities that it is willing to assume, and it need not assume any other liabilities. Consequently, some hospitals may be reluctant to purchase stock instead of assets. Second, some additional tax cost may be incurred by the hospital or its clinic subsidiary in a stock purchase.

In most cases, the hospital's concerns may be addressed as follows. The liability stemming from the medical practice is usually adequately insured with general comprehensive liability and medical malpractice insurance. The insurance policies will follow the corporation with the purchase of its stock. As a result, it is highly unlikely that any uninsured liabilities will arise. With respect to the tax issues, if the stock is purchased by a taxable clinic subsidiary of the hospital, the clinic subsidiary can liquidate the medical practice on a tax-free basis following acquisition

of the stock.

If the clinic is operated as an "S" corporation, professional limited liability company, or partnership, no tax will be assessed at the entity level and a sale of assets will not create any greater tax liability for the physicians/shareholders or partners.

Governance Issues

Another crucial issue to consider is the control of the clinic operations following the acquisition. The transaction structure will directly affect governance. If the hospital purchases the assets directly, the physicians/shareholders will be subject to the governance structure in existence at the hospital. This purchase structure has certain tax advantages because the clinic division of a tax-exempt hospital will have unrestricted access to the hospital's capital, including funds raised through the issuance of tax-exempt bonds. Despite these tax advantages, the governance issues may be thorny. Physicians should seek appropriate board representation within the hospital organization, as well as representation on committees that influence clinic operations. Physicians may be informed that they may not represent more than 20 percent of the hospital's or clinic subsidiary's board of directors. Although a 20 percent "safe harbor" does exist for determining whether a "community board" has been established to satisfy a hospital's tax-exempt status, physician participation may exceed 20 percent if the board is structured properly. If the acquisition is undertaken through a clinic subsidiary of the hospital, the physicians should again negotiate appropriate representation on the board of directors, management committee, and other relevant committees. If the clinic subsidiary is a taxable entity, there is no limitation on physician representation because a "community board" is not required. As a result, a physician should be able to negotiate equal sharing of power with hospital representatives on the board of a taxable clinic subsidiary.

Sale structure and governance are key issues, but numerous other issues must also be addressed as part of the integration process, including valuation of the medical practice, employment terms, physician compensation, employee benefits, and retirement planning. These issues will be addressed in the second part of this article to appear in the May issue of *Minnesota Medicine.* MM

The preceding general discussion is designed to alert physicians to the legal issues that arise in the sale of medical practices. It is not legal advice and should not be relied upon as such.

Forrest Burke is a member of the Health Practice Group at Dorsey & Whitney in Minneapolis. He specializes in health care mergers and acquisitions and represents private and nonprofit business entities involved in the health care field on a wide variety of issues.

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Centennial Salute

Long-time Windom, Minnesota, physician Harold Stratte turns 100.

Kristi Belcamino

The past couple years have been eventful for Harold C. Stratte, M.D.; he caught a 33-pound lake trout in 1992, attended his 80th high school class reunion in 1993, and on April 2, 1994, he celebrated his 100th birthday. He plans to have just as much fun in the years to come. His 1993 Christmas card reveals his sense of humor about hitting the century mark: The front shows a picture of Stratte in front of his Windom, Minnesota, home, where he's lived since 1943. After describing the history of the house, his greeting says, "Not only is the house about a hundred years old, but I am, too. The pin I'm wearing says, 'If you think this is a gala affair, just wait until my hundredth.' "

Stratte spends most of the winter months with family on the West Coast. Daughter Georgia Stratte Smith, who lives in Washington, says her father rides his stationary bike daily, writes letters, and plays cards. Stratte says, "I dress myself, if you want to know. I get up in the mornings just like you do—get up in the morning and go to bed at night."

Stratte began his practice in the horse and buggy days of medicine, when the country doctor was almost a part of the family. His calls would come anytime during the day or night. "Lots and lots of house calls were made," daughter Georgia remembers. "Lots of late meals and changes in plans—maybe some baby was due or someone was very ill. I can well remember Daddy going out on calls at any hour of the night, returning home, hearing the phone ring again, and starting all over."

In those days of black bag medicine, many patients didn't have money to pay for doctors' services, and Stratte would often take a chicken or a dozen eggs, baked goods, and once, even an old blanket, as payment for his services. "More often than not, there would be an 'nc' on his books—meaning no charge," Georgia says.

"If [patients] were hard up, I didn't care," says Stratte.

"I used to make night calls and day calls," says Stratte. "And all the other doctors were just like I was—we enjoyed our work, we wanted to practice all the time, and we did. As far as I know, every doctor I ever knew enjoyed his work. And we didn't have to overcharge to make a living. I enjoyed practicing even on the first day, practicing as an intern, and on the last day—up to the last call I had" (in 1986 at age 92!).

Patients would come in and talk for hours, and Stratte would never hurry them. He'd just sit and visit, even though at times the office would become pretty crowded, recalls his daughter.

Stratte grew up in Dawson, Minnesota. His father, Halvor Stratte, a pharmacist, emigrated from Norway to Dawson and was one of the first pioneers when the town was only three years old. Halvor owned Stratte Drugs in Dawson, where Harold Stratte worked writing prescriptions before he went to Carleton College in 1914. Stratte later transferred to the University of Minnesota and graduated from the Medical School in 1920. After graduation, he interned in New

York City in 1921 and returned to Minnesota to practice in 1922. He established his practice in Windom, Minnesota, in 1930, where he practiced for 56 years and still lives during the warmer months.

Stratte is one of the few World War I veterans still living. Even more remarkable, Stratte can remember, with his usual good humor, the Civil War veterans marching in parades in Dawson. "The worst of it was that I was in the band and I'd have to go play. We always had a meeting on Decoration Day, and I'd have to sit through all that before I'd play a piece with the band—which was torture for a kid," he says.

Last May, Stratte attended his 80th high school class reunion with Bertha (Hestad) Swenson. They were the only ones there—the two surviving members of the class of 1913. They met in first grade. "We lived in the same town and started school together the very first day," says Stratte. In 1988, 75 years later, they became reacquainted in Dawson, where Stratte's wife is buried and where Swenson, 99, is the former postmistress. Now, whenever he's in town, Stratte has lunch with Swenson, and they write when they're apart. "It's been a nice friendship," says Georgia. "I think these two are the only friends they have at this age level."

In 60 some years of practice and 100 years of life, Stratte has seen marvels in medicine and technology. "Well, of course there's new stuff coming up all the time," he says. "I'll tell you—in the old days when you broke your hip, you'd have to go to bed for six months or so, but now you go to bed for a couple days and they give you a cane and off you go. That's quite a change, don't you think?" Stratte is speaking from experience. He broke his hip two years ago and was up and home within a week. His daughter says the medics and doctors were astounded by his good health.

When asked how he has lived to see his 100th birthday, Stratte says, "I didn't do anything. It just came. I've never felt like I was 100, and I don't feel like I'm 100 yet." He plans on sticking around for a while. According to his daughter, Stratte once said, "The first 100 years were the easiest; it's the second 100 that are going to be hard."

Stratte eats and drinks most everything he wants, including a nightly meringue and an occasional cocktail. He says he eats a lot of candy, but doesn't overdo it. He doesn't worry about cream, sugar, or butter. "No, whatever tastes good, tastes good. I like it. I do have my three meals a day. I eat good food, not much for breakfast, though."

For those who want to live to be centenarians, he advises, "Have fun. Do what you're supposed to do, but have your share of fun. And I suppose you've got to behave, too," he adds, chuckling. MM

Kristi Belcamino is a publications assistant with Minnesota Medicine *and a free-lance writer.*

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LOVE

(continued from page 7)

and in the design of medical policy—either by becoming educated about the issues and becoming leaders themselves, or by electing leaders from their ranks and then supporting them.

A Physician Leader

A native of Canada, Love grew up in Edmonton, Alberta, and completed her postgraduate training in internal medicine and infectious disease at Toronto General Hospital and the University of Toronto in Ontario. She and her husband and two children moved to Minneapolis in 1982.

Love established her private practice, Infectious Disease Consultants, P.A., in 1986, and added Dan Anderson, M.D., in 1990. Anderson moved on to Atlanta, Georgia, in 1993 ("one of the first wave of talented physicians to flee MinnesotaCare and Minnesota taxes," says Love). Steven Sonnesyn, M.D., joined her practice in 1993.

Love is hospital epidemiologist and chair of the Infection Control Committee at Abbott Northwestern and is also on staff at Fairview Southdale, Fairview Ridges, Fairview Riverside, and North Memorial Medical Center. She is section head of infectious diseases at Abbott Northwestern's University of Minnesota-affiliated Unit for Teaching and Research and is a clinical associate professor of medicine at the university.

Like most physicians, Love's education did not include extensive courses in business administration.

"This is one of the biggest challenges to physicians providing leadership to PHOs and other similar structures," says Love. Education is necessary for physician leaders to succeed, and the issue of who will pay for such training is an area for discussion.

"One negative aspect of leadership is burnout. Physicians elect their leaders, and then they eat them up," says Love. "They must empower their leaders and trust them, even though hospital corporations sometimes pay for their time." (Love is not paid to chair Abbott's PHO.)

"Our biggest fears as physicians are of losing our autonomy and our ability to do what is right for our patients," she says. "We, as physicians, need to articulate a philosophy. We need to go beyond the exigencies of the present situation and define what we would like to see the doctor-patient relationship look like in the year 2000—what we want for the profession, for our patients, for our society, and for the next generation." MM

Pamela Hill Nettleton is a contributing editor to Minnesota Monthly *magazine and a Twin Cities freelance writer.*

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Providing Universal Health Care Coverage

C. Randall Nelms Jr., M.D.

"Imagine that you could purchase your own health insurance the same way you do automobile or homeowner's insurance—that you didn't rely on your employer to decide on the right plan for your family and that if you didn't get adequate service, you could readily switch carriers." I expect that most of our patients share this desire, expressed in a recent letter to the editor I read in a local newspaper.

"Marketplace competition will only work when we can provide health care coverage, access, and quality for everyone."

Universal Coverage and Insurance Reform

Is that desire so unreasonable? We at the Minnesota Medical Association think not. Our goal is affordable, accessible, and accountable health care for everyone—a goal the state is trying to achieve as well. The 1993 Legislature required the Minnesota Health Care Commission to develop a plan for providing universal health care coverage, and the commission has recommended that individuals be required to purchase health coverage. For that to happen, our insurance system must be reformed, and the commission realizes this. It has recommended that the Legislature require insurance companies to provide health coverage to anyone willing to pay the premiums and charge the same premiums for all enrollees. It recommends that health plans no longer be allowed to base premiums on health status and risk or to limit health care coverage because of preexisting health conditions. It recommends passing laws that enable individuals to move from public health insurance programs to private health plans and between health plans without restriction or exclusions, and it suggests requiring health plans to offer coverage to individuals as well as groups. Finally, it would like to institute one standard benefit set for all health plans, whether public or private, to serve as the floor of benefits for all Minnesotans.

Universal coverage addresses the financial barrier to access. Nonfinancial barriers related to geography, culture, language, race, transportation, and a shortage of providers also prevent people from getting the care they need. The Minnesota Medical Association recognizes that truly universal access to health care requires actions beyond insurance reform.

Quality Control

The quality of health care in the United States is one of the greatest strengths of our health care system. To guarantee high-quality care, physicians and their professional organizations must continue to control the standards that will ensure the provision of effective and efficient medical services. The patient and physician—not some third-party managed care company or government administrator—must manage care. We must not surrender independent medical decision making to "nonessential" players, who too often complicate the one-to-one physician-patient relationship for their own gain.

Medical care is a local service. Therefore, any new health care system also must be designed to preserve local control. Right on target is the concept of community integrated service networks (CISNs) proposed by the Minnesota Department of Health. That proposal calls for exemptions and flexibility to make it easier for smaller, community-based ISNs to meet licensure standards. CISN service areas would be allowed to develop naturally, rather than in conformity to a state mandated service area map. In addition, the proposal suggests establishing an ISN shared services cooperative to enable smaller ISNs to share administrative, legal, and other services.

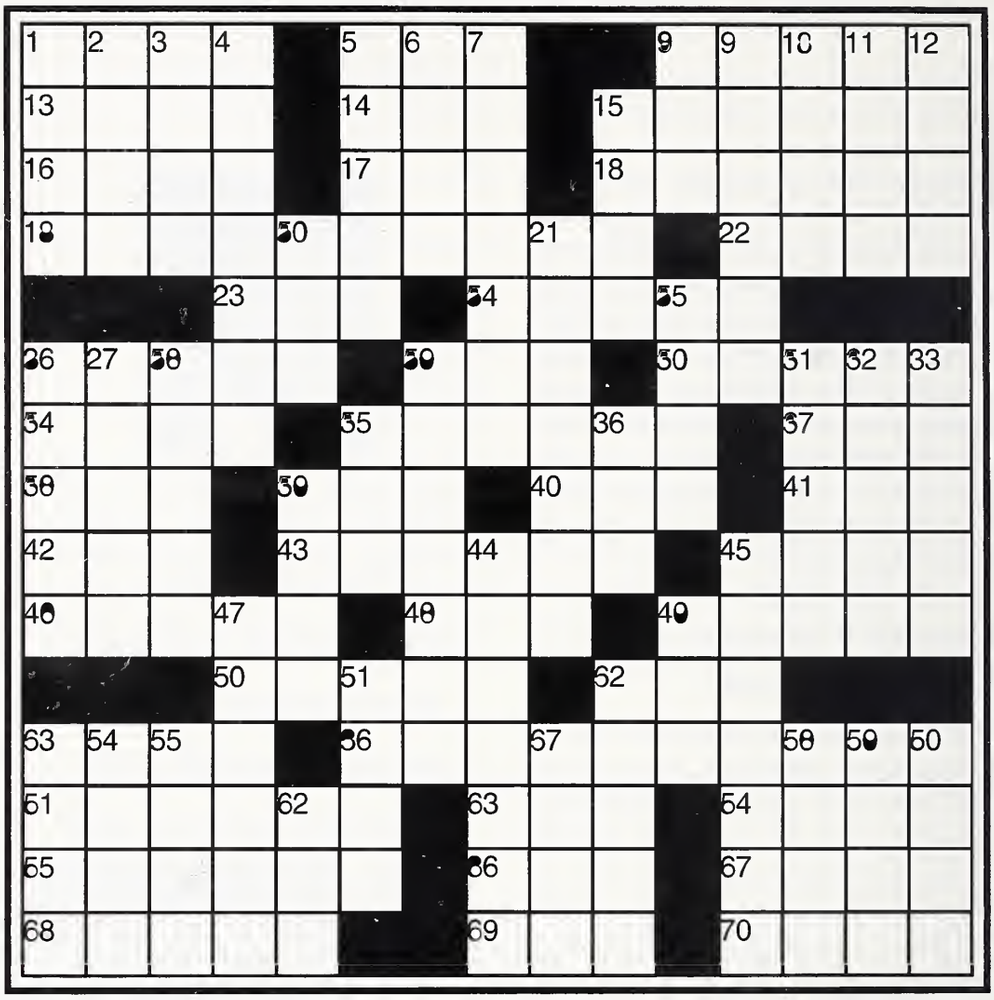
A Competitive Market

The marketplace competition hailed as the means of controlling costs and promoting quality will work only when we can provide health care coverage, access, and quality for everyone—when individuals are able to choose their physicians and their delivery systems. Individuals must be able to select physicians based on professional skills, location, personal preference, recommendations from other physicians and friends, along with cost and service considerations. All Minnesotans should be able to purchase individually owned, affordable health care coverage that is accessible and accountable to the local population. MM

CROSS WORD PUZZLE

By Ernest Lampert, M.D.

ORTHOPEDICS



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ACROSS

1. In a murderous frenzy
5. French friend
8. Soap plant
13. Tony, the golfer
14. A place of iniquity
15. Brother, can you ___ dime?
16. Algerian city
17. Song in *A Chorus Line*
18. Connects muscle to bone
19. The medial synovial space of 4 down
22. Charged particles
23. Sign of victory
24. Kind of pregnancy
26. FBI poster: ___ and dangerous
29. Apron worn over the chest
30. Immobilizes with plaster
34. River duck
35. Anterior ___ sign, in tear of cruciate
37. Stipend
38. Bulgarian unit of currency
39. Saint in Brazil
40. Rice paste
41. Intention
42. Enzyme
43. Pig Latin for vetoes
45. Can be reached by an adit
46. Berger, the actress
48. DOS command: results in prolonging monitor life
49. Gasps
50. ___ *and the Night Visitors*
52. Estop
53. Great distance
56. Deformity in a Colles fracture
61. ___ de Cristo; a range seen from Sante Fe
63. Form of John
64. Last word
65. Sign in carpal tunnel syndrome
66. Small bird
67. Hawaiian goose
68. Dills
69. Urban RRs.
70. Dagger

DOWN

1. Jesus, Mattie, or Filippe
2. Blackbird
3. Gulf, arm of the Arabian Sea
4. First expert on fascial hand space infections
5. Kind of hacienda
6. Carte
7. Resistance to change
8. Biped
9. A Luzon city
10. Church calendar
11. Ponce de ___, explorer
12. Gives birth
15. Pang
20. ___ sails in the sunset
21. Heroes
25. Israeli port
26. A cervical vertebra
27. Pee Wee ___, a shortstop
28. Expert
29. Trachea followers
31. Part of Iberia
32. Make impure
33. ___ amputation; at the ankle
35. Ger. stock index
36. Type measures
39. Locale of *The King and I*
44. Kind of diner, var.
45. Lincoln's syndrome
47. Bull's eye
49. Duffer's goal
51. Fruit drinks
52. Inclinations
53. Nora's dog
54. Rather
55. Boleyn, one of Henry's wives
57. Intramedullar ___, used to maintain reduction
58. Portent
59. Coty; a common Fr. first name
60. A hinge joint
62. Wrote *Kidnapped*

Solution on page 57

People and Places Making Medical News

People

AMA/Glaxo Achievement Award

Michael J. Achinger, a medical student from the University of Minnesota Medical School in Minneapolis, was one of 50 young medical professionals honored by the American Medical Association at its annual National Leadership Conference. The AMA/Glaxo Achievement Awards were presented to 25 medical students and 25 residents in recognition of their exceptional leadership abilities in medicine and/or community affairs. Achinger was recognized for his service as American Medical Association-Medical Student Section chapter president at his school, a member of the Hennepin County Medical Society Board of Directors, a member of the Minnesota Medical Association Medical Student Section Governing Council, the current student member of the MMA Board of Trustees, and the Section 2 representative to the AMA-MSS States Leadership Steering Committee.

Award winners received a grant to attend educational and informational sessions covering health care issues at the Leadership Conference.

HealthPartners-Ramsey Executives

Robert F. Garland, president and chief executive officer of Ramsey HealthCare, Inc., is the new chief operating officer of the Ramsey Division at HealthPartners, a vertically integrated health care delivery system that consists of a number of HMOs, multispecialty physician group practices, and a major teaching and tertiary care hospital. In his new position, Garland, who also holds the position of executive financial officer, joins the HealthPartners senior executive staff. Garland has been president and chief executive officer of Ramsey HealthCare, Inc., since July 1991. He joined St. Paul-Ramsey Medical Center in August 1984 and has held a number of executive financial positions in the organization, including chief financial officer, deputy executive director, and executive vice president.

David Fortney, former senior vice president and general counsel for St. Paul-Ramsey Medical Center, is now vice president and general counsel for HealthPartners. Fortney will oversee the provision of legal services to corporate officers and boards of directors for HealthPartners. He joined St. Paul-Ramsey Medical Center in 1986 as vice president and general counsel, became a senior vice president in 1990, and became associate general counsel for Ramsey HealthCare, Inc., the medical center's parent company, in 1991.

Dave Bergh, former vice president for information services at St. Paul-Ramsey Medical Center and Ramsey Clinic, is now vice president and chief information officer at HealthPartners. He will oversee the consolidation of the information services function at Ramsey with the information services function at HealthPartners. The combined department will provide support services for the health care plan and the integrated delivery system.

Entrepreneur of the Year

The Minnesota Entrepreneurs' Club named **Earl E. Bakken**, co-founder of Medtronic, Inc., as Entrepreneur of the Year for 1993. Bakken is often credited with kicking off Minnesota's high-tech medical revolution by co-founding Medtronic in 1949. The company is now a recognized leader in the field of biomedical engineering and is the largest manufacturer of cardiac pacemakers. Medtronic has spawned several businesses in recent years—Bradycardia Pacing, Tacharrhythmia Management, Cardiopulmonary Heart Valves, Interventional Vascular, and Neurological.

Caregiver of the Year

The Minnesota Association of Homes for the Aging has named **Mike Lorenz**, an L.P.N. for a dementia unit at Ebenezer Luther Hall in Minneapolis, its statewide Caregiver of the Year for 1994. The award honors an MAHA member employee who provides direct care and has been found to be outstanding in treating the whole person.

Lorenz has been described as "an extra special nurse" and "the epitome of excellence in serving those with dementia."

Minneapolis Children's Foundation

Minneapolis Children's Foundation, the fundraising arm of Minneapolis Children's Medical Center, has elected its 1994 board of directors. Elected officers are Chair **Kevin Roberg** of Eden Prairie, Diversified Pharmaceutical Services, Inc.; President **Nancy Larson Haskin** of Minneapolis, Minneapolis Children's Foundation; and Secretary **Martha MacMillan Bennett** of Long Lake, community volunteer. Newly elected directors are **Judson M. Dayton** of Wayzata, TCF; **Robert W. Gibson** of Edina, Wessels, Arnold & Henderson; **Scott Hugdahl** of Eden Prairie, Northwestern Mutual Life; **David D. MacMillan** of Orono, American Community Bank Group; **Patrick McDonnell** of Prior Lake, Harmon Contract; **Bonnie Roscamp** of Golden Valley, Association of Minneapolis Children's Medical Center.

HealthSystem Minnesota Director

HealthSystem Minnesota, parent company of Methodist Hospital, Park Nicollet Medical Center, Methodist Hospital Foundation, and HSM Associates, has hired **Mark Skubic** in the newly created position of director of public policy and government relations. He will be responsible for development and implementation of a public policy strategy for HealthSystem Minnesota and will represent HealthSystem Minnesota in public and private forums to advance policy directions consistent with the organization's missions and goals.

Before joining HealthSystem Minnesota, Skubic was manager of federal government relations for HealthPartners, Inc., and he has held positions with the Minnesota Department of Health, the St. Paul City Council, and the Minnesota State Senate.

Places

HealthPartners Plan Features Mayo

Mayo Clinic and HealthPartners have started a new health plan, "Mayo Choice," that will enable more Twin Citians to be treated at Mayo. Through the plan, enrollees receive coverage for health care services delivered through the HealthPartners and Group Health provider networks but may choose to receive care at Mayo Clinic in Rochester. They may visit Mayo Clinic at any time without a referral from their primary care physicians for covered diagnosis, testing, and treatment services. Patients who refer themselves will pay 20 percent of the cost of care. Members can make an appointment with Mayo doctors by calling an 800 number.

HealthPartners Launches New Wellness Program

HealthPartners has launched a program to focus its organization on promoting health, rather than just treating illness. The "Partners for Better Health" program plans to bring providers, members, and the community together to prevent illness and improve the health of people who are at high risk for certain diseases.

The plan has set aggressive four-year goals in six areas.

- Reduce the number of heart disease events, e.g., heart attacks, by 25 percent.
- Increase from 75 percent to 95 percent the number of children who are fully immunized for childhood diseases by age 2.
- Improve the early detection of breast cancer, reducing by 50 percent the number of cases going undetected before reaching advanced stages.
- Increase the early detection of adult onset diabetes by screening 90 percent of high-risk members. Reduce by 25 percent the progression from a high-risk state to active diabetes. Reduce by 30 percent the onset and progression of eye, kidney, and nerve damage resulting from diabetes.
- Reduce by 30 percent the infant and maternal complications among HealthPartners members.
- Reduce new dental cavities by 50 percent for all age groups with HealthPartners dental coverage.

To help achieve its goals, HealthPartners will identify which of its members belong in one of five categories: low risk, at risk, high risk, early symptoms, and active disease. The plan will then work with members to reduce their risks.

HealthPartners will also offer free dietary advice to restaurants and workplace lunchrooms and will ask supermarket managers to display healthy foods more prominently.

HealthPartners President and CEO George Halvorson said the program will cost $3 million to $10 million, depending on the number of potential cases it discovers. "If we show an overall 2 percent improvement in health status, we'll come out ahead," he said.

St. Paul Eye Clinic Donating Care

Staff at the St. Paul Eye Clinic and the Midwest Eye and Ear Institute in St. Paul are volunteering their time to provide surgery and follow-up care free to needy people who don't have insurance. The program, part of a nationwide project called Mission Cataract U.S.A. '94, will help about 20 people in the Twin Cities area. Nationally, the program is expected to involve 400 ophthalmologists and provide about $4.5 million in care to about 1,500 people.

United HealthCare Buying Florida HMO

United HealthCare Corp., based in Minneapolis, plans to buy Ramsay-HMO Inc., which serves Miami, Fort Lauderdale, and Palm Beach in Florida. The stock deal is valued at about $507.4 million. The deal, which is expected to be complete in May, will be United's most expensive purchase to date. It is its second purchase of an HMO firm in the Southeast.

United HealthCare reported record revenues and earnings for the fourth quarter and 1993, including a 55 percent 12-month net earnings gain over 1992 and a 64 percent gain in fourth quarter earnings over last year's fourth quarter. It also experienced strong enrollment gains in its health plans and specialty companies, not including the gains achieved through two acquisitions.

Mayo Adds New Helicopter to Fleet

Mayo One has introduced a new Bell 230 helicopter for rapid air transport of critically ill and injured patients in poor weather conditions. "Mayo One's new aircraft will allow us to transport patients in marginal and inclement weather," said Scott Zietlow, M.D., Mayo One co-medical director. "Our experience shows that motor vehicle accidents tend to occur in bad weather. In the past, the greatest need for rapid air medical transport occurred when our aircraft was grounded. The new aircraft will allow us to better

meet that need."

The helicopter, based at Saint Marys Hospital in Rochester, will fly using instrument flight rules, rather than relying on visual flight rules, which will allow Mayo One to fly when weather conditions and visibility are poor.

Mayo One is a unified air medical transport service based at Saint Marys and at Luther Hospital, a Mayo Regional Hospital in Eau Claire, Wisconsin. Mayo One transported 732 critically ill or injured patients in 1993—635 flights from Saint Marys and 97 from Luther.

HealthEast Opens Urgent Care Clinic

HealthEast closed its Divine Redeemer Hospital of South St. Paul March 20 and opened a HealthEast Urgent Care Clinic at the site. The clinic staff will treat minor injuries, general medical disorders, and childhood illnesses, while more serious emergency cases will be referred to the nearest health care facility after an urgent care physician makes an assessment. The HealthEast ambulance units that provide 911 mobile paramedic response to nine northern Dakota County communities will continue to operate from the hospital campus seven days a week, 24 hours a day.

The urgent care clinic is open 5 p.m. to 11 p.m. weekdays and 11 a.m. to 11 p.m. weekends and holidays to complement the normal hours doctors see patients at community clinics. Residents treated at the center will be referred back to their family doctors or on to a higher level of medical care at the time they check in. The patients will be provided aftercare instructions, and if they do not have a personal doctor, the center will help them locate one through HealthEast Tele-Health, the hospital system's physician referral service.

Medical School Using Fewer Dogs

The University of Minnesota Medical School has stopped using dogs in a physiology course and has dramatically reduced their use in a class on basic surgery. University officials say the reductions are not related to years of protests from animal rights activists, but instead are an effort to save money. The change affects the use of animals in teaching, not research.

Using the dogs is getting more and more costly, said William Jacott, M.D., associate vice president for health sciences, in a Minneapolis-based *Star Tribune* article. He said the classes may use dogs again in the future if they get more funding, but, for now, the physiology class will switch entirely to videotapes, and the surgery course will be cut from 10 sessions to between two and four.

Socioeconomics

HealthPartners Drops Aspen

HealthPartners is dropping Aspen Medical Group, which includes about 120 doctors and other professionals in eight Twin Cities clinics, from its network of providers as of May 1. HealthPartners members who enroll in an Aspen clinic before May 1 will be able to continue using the clinic until their groups' next open enrollment period, but after May 1, new enrollees will not be able to choose Aspen clinics.

Mary Brainerd, executive director of MedCenters, a HealthPartners plan, said officials decided to cut business with Aspen after the clinic announced last fall that it had merged its business systems with Blue Cross and Blue Shield of Minnesota, which later announced plans to form a network with Aspen and the University of Minnesota Hospital and Clinic and Fairview Hospitals.

Cost Increases for Health Care Benefits in Single Digits

Health care benefit increases for U.S. employers were held to single digit percentages last year, according to a survey by the consulting firm Foster Higgins. Costs rose 8 percent in 1993 to an average $3,781 per employee, compared with $3,502 in 1992, according to the survey of nearly 2,400 employers nationwide.

Benefit costs rose 10 percent in 1992, but Foster Higgins changed the survey substantially in 1993, so direct statistical comparisons aren't valid, said spokesperson Ed Emerman. "What you can say is that last year broke a five-year string of double-digit increases," he said.

Among the reasons for the smaller increase, Foster Higgins said, workers continue to move out of high-cost indemnity plans and into lower-cost managed care alternatives; competition has increased among managed care plans; and health care providers have attempted to hold down price increases temporarily in hopes of heading off government health care changes.

The cost of preferred provider organizations rose 5.5 percent, point-of-service plans rose 8.9 percent, HMO plans 6.5 percent, and traditional health insurance plans 7.1 percent. The latter remained the most expensive option, averaging $3,500 per employee. Preferred provider plans averaged $3,317 per employee, point-of-service plans $3,266, and HMOs $3,276.

EBP Offering New Health Plan

EBP Life Insurance Cos., a subsidiary of Employee Benefit Plans, Inc., in St. Louis Park, is planning to start a new health insurance plan in Minnesota, probably sometime this month. The company plans to market the plan to small and medium-sized employers. Buyers would pay EBP a set amount of money each month for care through a network of physicians, and policyholders could pay an additional amount to go to a physician outside the network. EBP is contracting with Bloomington-based Ethix Midwest Corp. to use its network of physicians.

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vides products and services to employers throughout the country that self-fund their employee benefit programs.

Group Health Won't Reduce Seniors' Premiums

Group Health has refused to roll back premium increases for "angry senior citizens" who have complained about this year's double-digit increases for Group Health's two HMO-Medicare plans. George Halvorson, president of Group Health and its parent company, HealthPartners, said the company cannot reduce the increase because Group Health is already subsidizing its Medicare plans. In March, Halvorson answered questions from more than 100 senior plan members at a session sponsored by the Minnesota Senior Federation. He told members that Group Health would not drop its co-payments of $10 per doctor visit and $30 per hospital emergency room visit for Medicare members because competing plans are using them to hold down their premium increases, and the trend in Minnesota is toward out-of-pocket charges.

Halvorson urged seniors to lobby instead for a change in federal law that would improve reimbursement to Minnesota health plans for providing care for Medicare recipients. He said the federal government diverts Medicare money from Minnesota—which provides cost-effective health care—to states with inefficient health care systems.

Rates, Trends, Data

Panel Calls for Reducing Physician Ranks

The Council on Graduate Medical Education has called for reducing the number of new physicians by 25 percent. Its proposal includes limiting the number of first-year medical residencies to about 19,000 from the current 24,000 by the year 2000. It said at least half of new doctors should go into general practice as family physicians, internists, or pediatricians. It also would like to double the number of underrepresented minority students and eliminate shortages of physicians in rural areas and inner cities.

Medical Research

Nicotine Patch Improves Smoking Cessation Rates

A Mayo Clinic study has found that nicotine patches significantly improve the success rate of people enrolled in a smoking cessation program and that success in stopping may be related to the dose of nicotine in the patches.

The study, which appears in the February 23 *Journal of the American Medical Association*, found that 27 percent of smokers who used nicotine patches in conjunction with a smoking cessation program developed by the National Cancer Institute were non-smokers a year after completing the program. This compares with 14 percent of people who received a placebo patch. The study involved 240 people who smoked at least a pack of cigarettes a day.

The NCI method alone resulted in significantly higher cessation rates than quitting "cold turkey" (3 percent success rate) or using physician counseling (up to 8 percent), said Lowell Dale, M.D., of Mayo's Nicotine Dependence Center and a director of the study.

Richard Hurt, M.D., director of Mayo's Nicotine Dependence Center and chief author of the report, said the study also provides evidence that increasing the dose of nicotine in patches could further improve stop rates. Only a third of the patients in the study received an amount of nicotine equal to the level their body was accustomed to from smoking, as measured by nicotine levels in their blood when they entered the program and eight weeks later at the end of patch treatment. The study used patches with a 22 mg dose of nicotine.

"The group of patients who had the lowest baseline nicotine levels had the highest stop rates of anyone in the study," he said. "This is the first time that a relationship has ever been shown between outcome and baseline nicotine levels in the blood for smokers receiving nicotine patch therapy."

Study Trying to Prevent Diabetes

The University of Minnesota is one of 10 medical centers participating in a national study to test whether Type 1 diabetes can be prevented in high-risk people by giving them insulin before they develop the illness. The study, sponsored by the National Institutes of Health, will screen up to 80,000 relatives of people with insulin-dependent diabetes and will choose 830 for the study. The $30 million study will last five to seven years.

Animal experiments and limited human experiments indicate that it may be possible to prevent the progression of Type 1 diabetes with small doses of insulin. "We hope it will prevent diabetes altogether, which would be a tremendous success," said Paul Robertson, M.D., head of the Minnesota phase, in a Minneapolis-based *Star Tribune* article.

The Mayo Clinic in Rochester and the International Diabetes Center at the Park Nicollet Medical Center in St. Louis Park, Minnesota, will collaborate in the study. For information on volunteering for the study, call 612/626-6000.

Stroke Treatment Has Improved

University of Minnesota researchers have found that Twin Cities area residents have a better chance of surviving a stroke now than they did in 1980. They attribute the increased survival rates to improved treatment but say there may also be a trend toward some cases being less severe.

Researchers looked at medical records of area residents aged 30 to 74 who were treated for strokes,

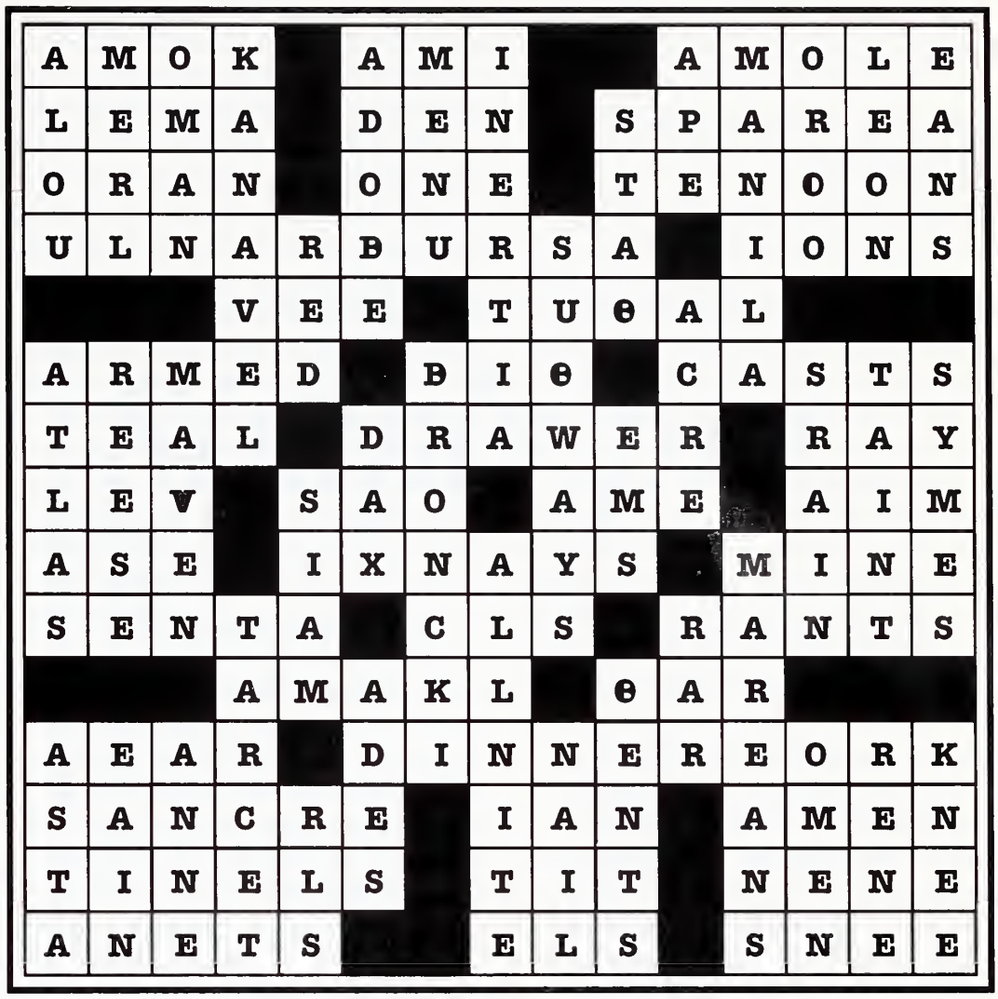
and they found that a patient's risk of dying within four weeks of suffering a stroke was about 15 percent in 1990 compared with about 25 percent in 1980. In addition, a patient's chance of dying within a year was about 25 percent in 1990, compared with about 35 percent in 1980.

The number of stroke deaths has been falling since the 1960s and, up to now, the assumption was that fewer people were having strokes because of better control of blood pressure and other preventive measures. This study shows that more Twin Citians are surviving strokes, as opposed to fewer people having strokes. Eyal Shahar, M.D., the university epidemiologist who headed the study, cited two possible reasons: Some people may have less severe strokes because of better treatment for high blood pressure, and improved treatments for stroke may be increasing survival.

Tamoxifen May Be Risky

New data confirm that the drug tamoxifen, which is being tested for its ability to prevent breast cancer in women at high risk for the disease, can cause other cancers. As a result, officials from the Breast Cancer Prevention Trial are changing the consent form provided to the 16,000 women enrolled in the study.

Study leaders had previously acknowledged that tamoxifen may increase a woman's risk of developing uterine or liver cancer and blood clots, but results from a long-term, nationwide study of breast cancer patients taking tamoxifen reveal that the risks of other cancers are real. The results from this study will be published later this year in the *Journal of the National Cancer Institute.*



Solution to crossword puzzle from page 52

AIDS Update

Minnesota Reports 2,000th AIDS Case

Minnesota reported its 2,000th AIDS case in March. The first 1,000 cases were reported over a span of nine years, while the second thousand have been reported during the last two and one-half years, although a change in diagnostic criteria makes comparisons imprecise. At least 1,133 of the 2,000 Minnesota AIDS patients already have died, according to Richard Danila, an AIDS epidemiologist at the Minnesota Health Department. About 275 new cases are expected to be reported in Minnesota this year.

AZT Reduces HIV Transmission to Newborns

AZT dramatically reduces transmission of HIV from infected mothers to newborns, according to study results announced by the National Institute of Allergy and Infectious Diseases. Because the findings are considered so significant, the study was halted in February. Government officials notified the 59 participating medical centers in the United States and France to offer AZT to all pregnant women who had been receiving only a placebo. In addition, data from the study were distributed as a "clinic alert" through the National Library of Medicine, which has a computer network available to health care workers around the world.

Harold Jaffe, M.D., an epidemiologist at the Centers for Disease Control and Prevention, said the finding was one of major public health importance. "It is the first indication that mother-to-child transmission of HIV can be at least decreased, if not prevented," he said, "and it will provide a real impetus for identifying more HIV-infected women during pregnancies so that they could consider the benefit of AZT treatment to themselves and their children." MM

LETTERS

(continued from page 3)

Extracting the Pertinent from the Irrelevant

We read with interest the timely piece, "Coping with Information Overload," in the January *Minnesota Medicine*. The article dovetailed neatly with recent efforts on the part of HealthSpan Library Systems and Services to address the information-related challenges facing physicians in our provider network. Medical librarians have long been aware of the information glut and the difficulty of extracting pertinent material from a plethora of clinical irrelevancies. How important will this issue become for clinicians? As more and more physicians gain access to the electronic literature via desktop computers, we believe that the information deluge will seem more problematic. Furthermore, the ability to properly find and interpret the medical literature will be directly related to clinical decision making and optimal patient care.

The Evidence-Based Working Group of the AMA has described what it calls evidence-based medicine as the new paradigm for clinical practice. In the future, clinical decision making will be partially based on the best evidence available in the published medical literature. The resolution of clinical problems will begin with a literature search for statistically valid overviews and practice guidelines. It is thought that excellent patient care in the 21st century will require a competency on the part of physicians to use the medical literature in solving clinical problems.

HealthSpan Library Systems and Services is in the business of assisting clinicians in delivering evidence-based patient care. We have made a commitment to helping its clinicians sort through, interpret, and evaluate the vast medical literature. We are publishing literature search strategies in our departmental newsletter to teach physicians how to narrow retrieval to the most clinically relevant journal citations. We support and administer end-user literature searching, and we provide computer workstations in our libraries for end-users to search MEDLINE and other health-related databases. Remote access to the same constellation of databases from the home or departmental office via LAN-based network is also a library-administered function.

Clinical decision making is still viewed as one of the changeable aspects of health care delivery. Health care expenditures are obviously affected by physician activity, including the ordering of laboratory tests, diagnostic procedures, and treatment plans. Much of the information necessary to make appropriate clinical decisions can be discovered in the published research. We believe that a working partnership between medical library systems and physicians will promote the practice of evidence-based medicine.

Andrea K. Potter, M.L.S.
Reference Librarian
Abbott Northwestern Hospital
Minneapolis, Minnesota
Donna P. Johnson, M.L.S.
Director, HealthSpan Library/Media Systems and Services
Minneapolis, Minnesota

When It's the Only Game in Town

Editor's Note: The following is a response to the February article, "When the Game Is What Counts," written as a letter from a physician (George) to an attorney (Ben).

Dear George,

I've been wondering why you've been so distant lately. Your letter took me aback somewhat. I think I can clarify the differences in our positions.

Law, unlike medicine, has no empirical basis. It is not scientific, and we haven't the same controlled circumstances in which to practice. The nearest we have is the courtroom, and that is only barely controlled, as you know from your observation. Law is a highly codified system of arbitration that grew out of now distant folkways and mores, and it still derives from these previous influences. As such, law doesn't have the underpinnings of natural science that medicine enjoys. What we do in the practice of law is always unavoidably arbitrary. There are many more vagaries, and we deal with human behavior as the main tool.

Certainly, in the courtroom, law is a matter of game playing to a large extent. Drama is an inseparable component. Generally speaking, except for the most routine work, people come to lawyers when they have gotten themselves into circumstances they can't handle alone. In this sense, we have much in common with doctors. But we work on their problems without the controlled methods physicians enjoy.

We have another disadvantage. At least until recently, people generally liked doctors and trusted them. One of the reasons we lawyers observe camaraderie even after pitched battles in court is that we have very little other society. The second reason is that the practice of law might degenerate into complete anarchy if we didn't observe these civilities out of court. By the way, not all your colleagues are completely congenial toward one another, as some of my colleagues can testify.

It is true that juries have no special knowledge of medicine or science. Neither do most lawyers. In that sense, we are just common folk like those we represent, and we must work with what we have. Our society could hardly let doctors alone decide when and whether a physician has done harm. I think you can imagine why.

One aspect of law that is important to you is the protection it provides you and the civil method it provides for compensating your mistakes. How would you like to return to "an eye for an eye and a tooth for a tooth"? Not many physicians would make it to the end of their careers physically complete. By the way, I don't think Hippocrates said do more good than harm; he said, above all else, do no harm. Your colleagues could

avoid many of the claims against them if they kept this admonition foremost in their minds.

Yes, the work we do is flawed. This is inevitable in a flawed society like the one in which we live. Like doctors, we try to make things better. We have our opportunists, perhaps too many, but the medical profession has more than a few, too.

So, my friend, if you will give some thought to what I say, you will see that your outlook is more than slightly biased, and we are not so different after all. Neither of our professions is a study in unflawed behavior and unsullied virtue.

I remain your friend.

Ben

An anonymous lawyer from Edina, Minnesota

Chastity: An Idea Whose Time Has Returned?

In discussions of the AIDS epidemic, chastity is usually passed over quickly. Scientifically and mathematically, however, either no partners or one partner for life is ideal for sexual health. Why?

- Sexually transmitted diseases would essentially be eliminated. Except for unusual scenarios, disease-free faithful partners, who also avoid injecting street drugs, would remain disease-free.
- We would see fewer "unwanted" pregnancies. Even unplanned pregnancies are easier to face with the support and encouragement of a faithful partner.
- Chastity is psychologically healthier. Divorce and "cheating" are not easy. All the intuitive indications are that the sexual relationship is meant to be permanent.
- Chastity removes the basis for a great deal of poverty and economic difficulty. After divorce, a woman's average standard of living drops. Women and children are the new poor.
- Many other social problems are reduced. It is no secret that a child in a stable two-parent home does better psychologically and academically.
- Sex is ultimately more enjoyable when it is exclusive. Anything casual loses significance. The mystery and the desirability of sex increase if it is saved for one. Variety is not spice, but slow poison.

We have foolishly allowed our kids to shipwreck on the shoals of sexuality by abandoning the old lighthouse!

Ross S. Olson, M.D., Pediatrician
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A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

APRIL 1994

Apr. 7-8 **Annual Ob/Gyn Update** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 7-9 **Nineteenth Annual Spring Continuing Education Seminar** Minnesota Academy of Physician Assistants; Holiday Inn-Airport, Bloomington, MN. CONTACT: Sonja L. Gedko, PA-C, 8575 Magnolia Trail, 203, Eden Prairie, MN 55344; 612/944-9388.

Apr. 8 **ENT Update** St. Paul-Ramsey Medical Center; St. Joseph's Hospital, St. Paul, MN. CONTACT: Bonnie Young, Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 8-9 **Pediatric Advanced Life Support** Minneapolis Children's Medical Center; Minneapolis Children's Medical Center, Minneapolis, MN. CONTACT: Betsy Julius, Minneapolis Children's Medical Center, 2525 Chicago Avenue South, Minneapolis, MN 55404; 612/863-6206.

Apr. 12-14 **Religion and Sexual Health: Norms, Boundaries, & Justice in Church & Synagogue** University of Minneosta; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Apr. 14-16 **Trauma of Upper Extremity Fractures and Dislocations of Wrist, Elbow, and Shoulder** Mayo Foundation; Scottsdale, AZ. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME, Siebens 5, 200 First Street SW, Rochester, MN 55905; 507/284-2509 or 800/323-2688.

Apr. 15 **The 10th Annual Duluth Heart Conference** Duluth Clinic; Duluth Entertainment and Convention Center, Duluth, MN. CONTACT: Rockie Odberg, 400 East Third Street, Duluth, MN 55805; 218/725-3838.

Apr. 15 **Ventricular Arrhythmias** University of Minnesota; Earle Brown Heritage Center, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Apr. 15-16 **Seventeenth Annual Update in Clinical Cardiology** Minneapolis Heart Institute Foundation; Radisson Plaza Hotel, Minneapolis, MN. CONTACT: Don Young, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

Apr. 16 **The Treatment of Prostate Cancer** Minnesota Urological Society; Minneapolis Hilton and Towers, Minneapolis, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875.

Apr. 21 **Medica Foundation/University of Minnesota Lecture Series on "The Task of Medicine: A Rich Past and an Open Future"** Program in Human Rights and Medicine, University of Minnesota, Continuing Medical Education; Grand Ballroom, Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Mary Krumholz, 1121 Marion Street, St. Paul, MN 55117; 612/487-9715.

Apr. 22-23 **Minnesota Orthopaedic Society 10th Annual Meeting** Minnesota Orthopaedic Society; Siebens Medical Education Building, Rochester, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875.

Apr. 25-26 **Advanced Trauma Life Support (ATLS)** HealthSpan; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7910.

Apr. 25-29 **Family Practice Review and Update 1994** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Apr. 27-29 **Problem Oriented Case Studies in Surgical Pathology** Mayo Medical Laboratories; The Marriott, Amsterdam, the Netherlands. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Apr. 29 **Agricultural Health & Safety** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 29-30 **Pelviscopic Surgery Including Laparoscopic Hysterectomy** Abbott Northwestern Laser Center; Abbott Northwestern Hospital, Minneapolis, MN. CONTACT: Don Young, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

Apr. 30 **Minnesota Society of Pathologists Spring Seminar** Minnesota Society of Pathologists; Hennepin County Medical Center, Minneapolis, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875 or 800/999-1875.

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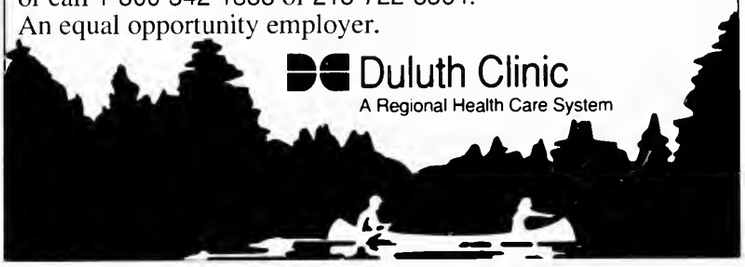

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MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

BC/BE Internal Medicine and Ob/Gyn Physician: Excellent opportunity to join a well-established, progressive, 26-physician multispecialty group located in an economically sound community of 22,000 (drawing area of 45,000), 65 miles south of the Twin Cities. Full membership after one year. Competitive salary and fringe benefits package. Contact Craig Oien, M.D., or Terry Tone, Administrator, 134 Southview, Owatonna, MN 55060; 507/451-1120. (9/92-R)

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Olmsted Medical Group is seeking BC/BE physicians in the following specialties: orthopedics, radiology, family practice, emergency medicine, and ob/gyn. Great opportunity for well-trained physicians to join a 55+ physician multispecialty group in a dynamic, progressive practice. In addition to the main office in Rochester, the group operates eight branch offices in southeastern Minnesota. Excellent salary/benefits package includes malpractice insurance, flexible benefits plan, 401(k) and profit sharing, and relocation assistance. Send CV to Olmsted Medical Group, Attn: Susan Schuett, 210 Ninth Street SE, Rochester, MN 55904. (1/92-R)

Internal Medicine and Dermatology practice opportunities available at the Faribault Clinic. The Faribault Clinic is a multispecialty group practice of 18 physicians. Faribault is located 50 miles south of Minneapolis on I-35. For more information contact Ray W. Wood, M.D., or Ken Smith, Administrator, 924 NE First Street, Faribault, MN 55021; 507/334-3921. (4/94-R)

Stillwater: Twenty-physician multispecialty group with emphasis on primary care seeking BC/BE family physician. Scenic location with excellent school system, supportive medical community with strong local hospital, competitive salary and benefits. Send CV to Jon Pedersen, St. Croix Valley Clinic, 921 South Greeley, Stillwater, MN 55082; 612/439-2215. (9/93-R)

Family Physician wanted to join five-physician, two-P.A., two-site family practice group in St. Anthony and Shoreview. Ob available. Competitive salary, benefits package, and call schedule. Contact Gerald Pitzl, M.D., Silver Lake Clinic PA, 612/788-9251. (7/91-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

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Family Practice, Surgeon: Five family practice group seeks surgeon, plus one or two family practice physicians. Population 8,000. One hour south of Burnsville Center. Lakes, industry, negotiable salary. Clinic adjacent to hospital. Ample free time to enjoy family life. Contact James W. Dey, M.D., or Ruth Hawker, Clinic Manager, 501 North State Street, Waseca, MN 56093; 507/835-3110. (9/93-R)

Mora, Minnesota: Aggressive, young, seven-physician family practice group seeks to add one or two physicians. Mora is a friendly community located one hour north of Minneapolis/St. Paul. There is abundant outdoor recreation in the area, including Mille Lacs Lake. The town is host to the Vasaloppet Ski Race, a half-marathon, canoe race, and bike race. If you are interested in this practice opportunity, and you should be, please contact Peter J. Donner, M.D., Mora Medical Center, Ltd., Mora, MN 55051; 612/679-1318 (wk); 612/679-1981 (hm). (11/92-R)

Occupational Medicine Specialist, BC/BE, FT, to join established group of eight physicians providing care for diverse employer-client base in St. Paul and Eagan, Minnesota. Excellent communication skills, strong commitment to patient care with MRO and IME experience. Competitive earnings and benefits. Contact Debbie Modder, HealthSpan, 2810 57th Avenue North, Minneapolis, MN 55430; 800/248-4921 or 612/574-8803. 1-4/94

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(*3/93-R)

Wisconsin—Family Practitioner Needed by progressive and growing group practice in west-central Wisconsin city of 60,000. Ninety miles from Minneapolis/St. Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high-quality care in a good recreational area. Send CV to James A. Volk, M.D., Medical Director, PO Box 3217, Eau Claire, WI 54702-3217; 715/836-8552. *3-6/94

General Surgeon, BC/BE, to join progressive 24-physician multispecialty group practice. Rural setting with metropolitan practice style, 25 miles from Minneapolis. Group has excellent reputation and large geographical referral area. Recently expanded facility is adjacent to newly remodeled 110-bed hospital. Comprehensive benefits package with excellent remuneration. Interested surgeons should contact Donald E. Somers, M.D., Lakeview Clinic, Ltd., 424 State Highway 5 West, Waconia, MN 55387; 612/442-4461. AA/EOE. 3-6/94

Full- or Part-time Family Physician or internal medicine physician for outpatient family practice clinics. No ob, ER, or hospital responsibilities. Very progressive north lakes practice located in Pequot Lakes and Pine River, Minnesota. Contact Carolyn Bridge, Pine and Lakes Clinics, PO Box 88, Pine River, MN 56474. 6-6/94

Internal Medicine—Twin Cities/Northwestern Suburbs: Busy, young, four-physician practice. Excellent salary and benefits for the right BC/BE physicians interested in all aspects of internal medicine. Growing hospital and clinic practice expanding to new site. No management duties or buy-in required. Send CV/call Lex Nerenberg, M.D., Bass Lake Physicians, PO Box 29188, Minneapolis, MN 55429; 612/537-6022. (3/93-R)

Northern Michigan: Excellent opportunities for BC/BE physicians in family practice, internal medicine, neurology, psychiatry, and gastroenterology to establish practices in a recreational, northern-Michigan, family-oriented community. Salary guarantees with excellent benefits. Send CV or contact Susan Khoury, Dickinson County Memorial Hospital System, 400 Main Street, Norway, Michigan 49870; 800/236-3240. *3-5/94

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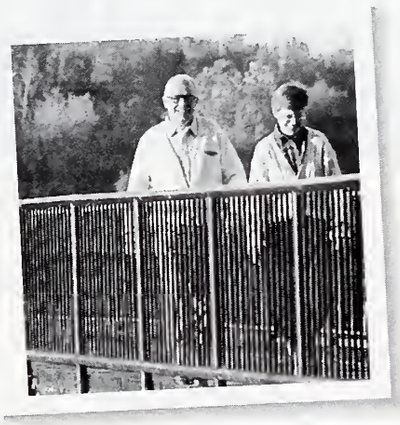

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Family Practice, Emergency Medicine, Internal Medicine, Locums, Ob/Gyn, Occupational Medicine, Pediatrics, Urgent Care opportunities available in Minneapolis/St. Paul and leading communities within a 150-mile radius of the Twin Cities. Contact HealthSpan, Physician Services, 2810 57th Avenue North, Minneapolis, MN 55430; 800/248-4921 or 612/574-7627. *3-6/94

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Eugene, Oregon: 53-physician multispecialty group is seeking BC/BE family physician. Practice includes ob. Excellent schools. Abundant cultural and recreational opportunities. Near Cascade mountains and coast. Home of University of Oregon. Please send CV to James Schwering, Administrator, Oregon Medical Group, PO Box 1648, Eugene, OR 97440. *3-6/94

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Wisconsin: Mayo Clinic regional practice seeks invasive (non-interventional) BC/BE cardiologist to join top-notch multispecialty group. Complete cardiac services including open heart surgery. Call 1:6. Quality medicine, congenial colleagues. Competitive guarantee, comprehensive benefits. University, diverse recreational/cultural activities. Call or send CV to Jane Vogt, 222 South Central, Suite 700, St. Louis, MO 63105; 800/765-3055. Fax: 314/726-3009. 1-4/94

Minneapolis: BC/BE family practice physicians needed to join the Family Practice Department of a 376-physician multispecialty clinic in desirable Twin Cities area. Currently, we have positions available at our Brooklyn Center, Burnsville, and Shakopee offices. Salary and benefits are highly competitive. For additional information contact Patrick Moylan, or send CV and letters of inquiry to Physician Recruitment, Park Nicollet Medical Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3286. Fax: 612/924-2819. *2-5/94

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Third Annual Clinical Neurology and Behavioral Sciences Symposium: Acute Neurological and Psychiatric Illness: Friday, May 20, to Sunday, May 22, 1994, Landmark Resort and Conference Center, Egg Harbor, Wisconsin. Contact: Marshfield Clinic, Office of Medical Education, 1000 North Oak Avenue, Marshfield, WI 54449; 800/541-2895. 2-5/94

Full-time or Part-time Family Practice opportunity in a community clinic providing neighborhood-based health care. Full scope of primary care including limited prenatal. Candidates should be BC/BE and have desire to work with low-income, culturally diverse patients. Call or write: Sean Flood, M.D., or Nancy Briggs, Executive Director, North End Medical Center, 135 Manitoba Avenue, St. Paul, MN 55117; 612/489-8021. AA/EOE. 1-4/94

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Effective with the July 1994 issue of *Minnesota Medicine*, classified advertisements will be billed at the rate of $2 per word with a $50 minimum.

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Minnesota Medicine

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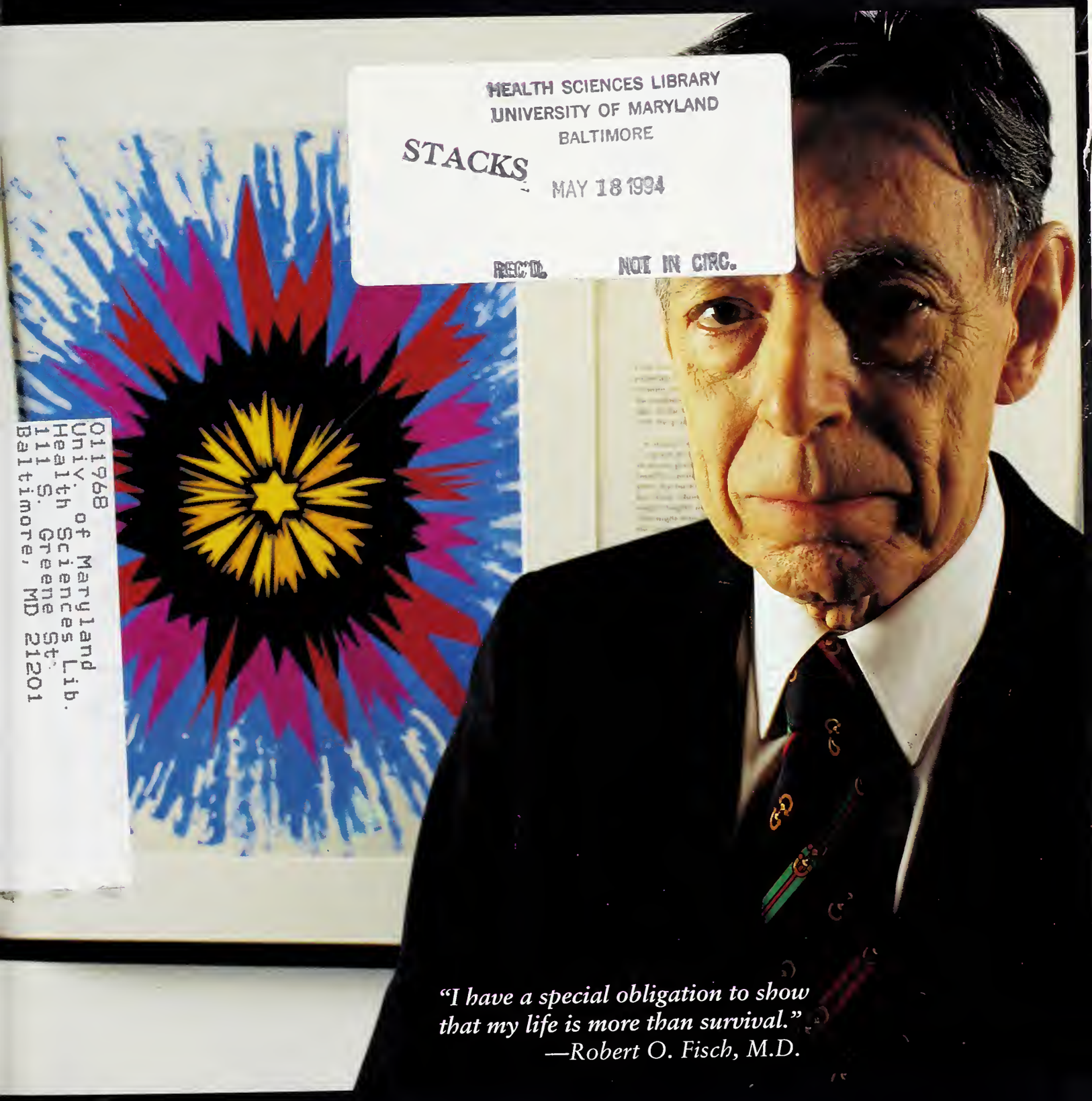

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Dr. Robert Fisch's art is on display at the University of Minnesota's Weisman Museum in an exhibit called, "Light from the Yellow Star: A Lesson of Love from the Holocaust (see article, page 6). Cover photo by Bruce Baird.

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Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

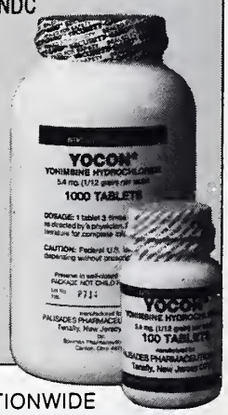
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



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The Treacherous Territory Beyond Physician-Patient Boundaries

Charles R. Meyer, M.D.

"Scary." Physicians might thus describe many trends of medical practice today. Predatory third-party payers, explosive overhead, and plummeting prestige conjure up visions frightening enough for Stephen King's best stories. But perhaps no threat is more chilling than a disruption of the physician-patient relationship. For practicing physicians, this relationship has great sanctity. It needs to function smoothly for medicine's essentials—diagnosing, treating, relieving, and caring—to thrive. Miriam Feldman's article, "When Doctors Cross the Line," describes trends that appear to imperil this hallowed interaction.

Feldman explores the treacherous territory beyond proper physician-patient boundaries. Physician sexual misconduct, ranging from overt sexual relations to improper comments and touching, is increasingly appearing in courtrooms, newspapers, and at the Board of Medical Practice. Although each case has its own twists, all represent a perceived violation of a code of conduct. Some of the violations are blatant, but some may strike physicians as unfair accusations, evoking a "What's wrong with that behavior?" response. As Paul D. Havens, M.D., said in a June 17, 1993, letter to the *St. Paul Pioneer Press*: "Our health, as a community, will suffer when patients are afraid to be examined and physicians are afraid to examine them."

Have the rules changed? Do physicians have to revise everything they learned about bedside manner? Society *has* changed in the past 20 years. Gender roles have altered. Sexual harassment and domestic abuse are pervasive and wreak vast emotional damage. The bland acceptance of perpetual male adolescence with its dehumanizing view of the opposite sex has been challenged and is, we hope, fading into historical oblivion. People question authority more freely, and hierarchical relationships are disappearing from home and office. All of this alters the people we see in our offices. Our patients' needs and expectations are different.

"Physician sexual misconduct is increasingly appearing in courtrooms, newspapers, and at the BMP."

But the basics are the same. The heart of the physician-patient relationship is communication. The heart of communication is knowing your listener. As society changes, so does the social and psychological fabric of our patients. More than ever, we need to know our patients and adapt our communication to the individual. Intelligible language to one patient is gibberish to another. Some patients welcome a joke, others see it as unprofessional. Patients may vary from visit to visit. All this is part of the art. It means listening to our patients' words, spoken and silent. It means explaining what we are going to do before we do it, and describing what we think as we diagnosis and treat. It means using language as clear and unsullied as possible. It means understanding that there are boundaries—social, psychological, financial, and sexual—over which we must not step if we are to fulfill our role as physicians.

Shortly after starting practice in the mid-1970s, I read a short article in the *Annals of Internal Medicine* by a female physician about doing pelvic exams. The article, which affects the way I practice medicine to this day, described the experience of a patient through the eyes of a physician. (Interestingly, I discovered that *Minnesota Medicine* reprinted the article in 1976. You'll find it again this month on page 8.) The author recommended brief explanations in neutral language to ease the patient through an invasive exam. It's a lesson equally applicable to the entire physician-patient relationship: Know your patients, sense their needs, and explain as you go. It worked nearly 20 years ago and it should work for a long time to come.

This Month's Profile

Rare is a physician who speaks the language of both science and art. Rarer still is a physician who brings personal experience of the Holocaust to these disciplines. Robert Fisch, M.D., belongs to that rare breed. His profile, page 6, sketches his past, his profession, and his painting.

Dr. Fisch's art and prose are on display through June 17 at the University of Minnesota's Frederick R. Weisman Art Museum. Through his exhibition, "Light from the Yellow Star: A Lesson of Love from the Holocaust," Dr. Fisch hopes to remind us that "love overcomes hate." MM

Healing Arts

Holocaust survivor Dr. Robert O. Fisch uses art and medicine to teach and to heal.

By Douglas Clement

As if moved by sudden inspiration, a man in a white smock leans forward and traces a thick, white curve on a black rectangle. He stands back, then leans forward again, and dabs white on black—a cloud-like shape to the right of the curved line.

Such motions often spread paint on canvas, but at this moment a doctor is using them to point out scoliosis on an x-ray, and then to indicate a minor lung infection that brought his young patient to St. Paul-Ramsey's pediatric clinic. "I vill give you an antibiotic for zis," he says to the girl's mother, in a thick accent. "But you must talk to your regular physician about zis curvature."

A few days later, the doctor is dressed in coat and tie, with a yellow rose in his lapel. To well-dressed patrons enjoying wine and cheese, he speaks of the artistic process that allowed him to create 17 paintings in six months, work that now hangs in the room behind them at the Frederick R. Weisman Art Museum at the University of Minnesota. "I honestly feel that the material of this show is not a product of my own abilities," he says in a quiet voice. "Rather, it came from within me. I was merely a tool, an instrument of its expression."

This humble "instrument" is Dr. Robert Fisch, a pediatrician, a writer, an artist, an exiled Hungarian. Since arriving in Minnesota 36 years ago, Fisch has brought a special talent to bear on both medicine and art. He is a professor of pediatrics and head of the child-care clinic at the University of Minnesota, a part-time pediatrician at St. Paul-Ramsey's pediatric clinic, and director of the university's Phenylketonuria Clinic. His prize-winning art has been exhibited in group and one-person shows in Minnesota, Washington, D.C., Memphis, and Atlanta, and his paintings and illustrations have appeared in books and medical publications, including *Minnesota Medicine.*

Many physicians have talents outside their profession, but few draw so successfully upon both their scientific acumen and their artistic abilities. If there is a common source for these inspirations, it is that Fisch—more than most of us—is a survivor.

In March 1944, when Nazis occupied Hungary, Fisch was an 18-year-old living in Budapest with his parents. For the crime of being Jews, both he and his father were detained, and Fisch was sent to a work camp. Here, Fisch and 280 others were forced to dig up unexploded bombs and build bridges. During Allied air raids, they were placed near munitions depots so that if bombs hit, "at least the ammunition would not be wasted." Three months later, only 120 of them were still alive.

Fisch recalls the German soldiers who shot a peasant when she

PHOTOGRAPH BY BRUCE BAIRD

The Exhibition

"Light from the Yellow Star: A Lesson of Love from the Holocaust," an exhibition of art and prose by Minneapolis pediatrician Robert O. Fisch, is on display at the University of Minnesota's Frederick R. Weisman Art Museum through June 17, 1994. The show explores the tragedy of the Holocaust through the eyes of Fisch as a young man in Nazi-occupied Budapest. "The purpose of this exhibition is not to make a memento of horror, but to know it and learn from it," says Fisch. "What I would like to be remembered is the beauty created by human virtue and enlightened by the spirit created by suffering. ... The Holocaust teaches this lesson: love overcomes hate." A book of Fisch's 17 gouaches and accompanying prose is also available. The text first appeared in the October 1989 Minnesota Medicine.

threw apples to starving prisoners. He remembers that his refusal to be sent to a hospital saved his life: Other prisoners also afflicted with typhus climbed onto the truck headed for the hospital, but they never arrived; the truck stopped and all 30 were shot to death. Just as clearly, however, he recalls acts of kindness, such as an SS soldier secretly handing out sandwiches to prisoners—the light of humanity appearing in the darkest hours.

In January 1945, Fisch was taken to a concentration camp near the Austrian border. "Imagine the oval brick burner building with its small opening filled with crawling skeletons," he wrote of the experience in *Minnesota Medicine* in 1989. "For two nights, we were forced to stay in the furnace room. The smell of decomposing bodies and incineration containers full of human excrement was indescribable. ... Millions of lice had invaded us."

When Allied soldiers liberated Fisch's work camp in May 1945, he was too weak to pick up the food they threw to him. Even a month later, on his 20th birthday, he was unable to climb stairs. Still, he was fortunate: Of 600,000 Hungarian Jews, only 80,000 had survived. Sadly, his father was not among them.

Fisch returned to Budapest, entered medical school, and eventually began a general practice. But the new Communist regime was as totalitarian as the Nazis, and Fisch fled across the border in 1956. He flew to New York and a year later relocated to Minnesota. In July 1958, he began a pediatric internship at the University of Minnesota Hospital and joined the faculty in 1961, when he also became director of the Phenylketonuria Clinic.

Knowing his tortured history, one expects to find Fisch a tortured man. Indeed, his face looks careworn, with deep furrows and dark eyes that have witnessed too much. It is a surprise, then, to find that he smiles quickly, laughs deeply, that he is a bit of a raconteur. "I enjoy very much the humor," he admits. "I think that I enjoy things much more than most people do. To me, to eat just one bite of bread is a joy."

Deprivation produced a generous spirit, as well,

FISCH continued on page 34

The Pelvic Examination

A View from the Other End of the Table

BY JONI MAGEE, M.D.

Lying on the examining table, feet in stirrups, confronting the examiner with the most personal parts of your anatomy, gives you plenty of time to think. Because I also perform pelvic examinations, I thought about what could be done to make me like them better. During the years certain parts of the procedure stood out as crucial. Speculum insertion is usually the most traumatic event in the examination. A detailed explanation of the sensations I experienced and suggestions for alleviating some of them are presented. Other aspects of the doctor-patient relation during the pelvic examination are explored and suggestions for improving patients' perceptions of them are offered.

One piece of advice I heard in medical school that I'll never forget came from the chief of surgery: every surgeon should have a laparotomy once a year. His opinion, clearly, was that nothing improves doctor-patient rapport more than shared experience. During my myriad pelvic examinations, instead of just looking at the ceiling, I thought a lot about why I didn't like most of them. After I became a resident in obstetrics and gynecology and was doing them myself, I got to understand exactly what the examiner was doing and started to think about what would make the whole business less unpleasant. What follows is the result of what started as my supine ruminations.

Once upon a time I was referred to the office of a world-renowned specialist for investigation of a problem with great emotional impact for me. My history was taken by one of the lesser lights, but the pelvic examination was to be done by the chief himself. I was taken to the examining room and positioned and draped in the usual manner, legs in stirrups, sheet over my knees so I couldn't see past them, my perineum exposed to whatever breeze might have been stirring. The great man entered the room, followed by two associates, and walked to the head of the table. There, towering above me, he extended his hand and introduced himself. I had a powerful urge to laugh hysterically, curse him, and kick him, but I smiled sweetly and said, "How do you do?"

NOW, AS THEY SAY ON SESAME STREET, "What's wrong with this picture?" Why did I react so violently? It took me years to figure out that the reason was that a handshake and an introduction imply a meeting between equals. However, that postural relation, with me in that very undignified, ludicrous, but necessary position, clearly implied that I was helpless—nowhere near equal. The whole scene was so ridiculous and demeaning that it was an extremely unpleasant experience. The moral of the story is that if you have arrived to do a pelvic examination, introduce yourself to your patient while she is still sitting up, preferably clothed, but, anyway, sitting up. It doesn't take very long for her to lie down, and she'll feel much more human and happy.

Then, there she is and there you are, sitting down there between her legs where she can't see you, getting ready to apply all sorts of unknown tortures. What do you do? Hum a little tune?

Many examiners do nothing. That is, they say nothing. For your patient's sake, talk! Tell her what you're going to do just before you do it. The shock value is greatly diminished that way. I usually say, "I'm going to touch the outside of your vagina and spread it apart. Now, I'm going to put my finger in. Now, relax!" That is, I used to say, "Relax," but I don't say it anymore. What is she supposed to relax? Her hands? Her toes? Her whole body? What you specifically want her to relax is the perineal floor, the levator ani muscle. But, if you tell her that, you won't get anywhere either. So, I tell her she has a muscle she squeezes closed when she has to go and can't get to the bathroom, and she should do the opposite of that. For good measure, you push down and out from just inside the introitus and tell her to relax the muscles you are pushing on.

NOW, YOU ASK, "What are you doing with your fingers in her vagina when the speculum examination comes first?" But first a word about speculums. Many patients call them "clamps." That evokes a frightening image. A rapid explanation that you're really not going to clamp anything soothes most jangled nerves. If you really feel like talking, you can even tell her what the speculum actually does. Next, they're cold, at least the metal ones are, and the plastic ones have other drawbacks. Anyway, lubricant spoils Papanicolaou smears and gonococcal cultures, so often you can't use lubricant with a speculum. But water doesn't spoil anything. And, if by some miracle there's some hot water around, you solve two problems at once by using it on the speculum. To actually insert this device, there are two methods. Because the introitus is vertical, it seems logical to insert the speculum in the anterior-posterior diameter and rotate it once it is inside. Before you do that, imagine someone's scraping a steel beam over your urethra. It's excruciating!

Back to your fingers. They allow a much kinder initial invasion than a cold, hard instrument. And while they are in the vagina, you can get a feel of the cervix so you know which way to point the speculum and how far in it needs to go.

ILLUSTRATION BY DARCY MYERS

Then you put it in right over your fingers, being careful not to touch the roof of the vagina. You put it in *slowly*. Very *slowly*. Five extra seconds can prevent your patient from feeling like a rape victim. Then, you open it. This is worth a special warning, like, "You'll feel like you have to go to the bathroom both ways at the same time." If you're using a plastic speculum, it locks open with a very startling click, which causes less anxiety if the patient is forewarned. It clicks again when you release it.

When you insert your fingers for the bimanual examination, slowness is again very important for comfort. Watch the patient's face. Don't ask her if it hurts; she'll tell you by her expression. You'll avoid a lot of decisions about whether a pain is significant that way. Because a pelvic examination does hurt. At least it's damned un-

EXAMS continued on page 34

ILLUSTRATIONS BY JANE MJØLSNESS

When Doctors Cross the Line

With complaints of sexual impropriety on the rise—most of them attributable to misunderstandings—physicians find they must approach their patients with greater sensitivity. • • • • • *Miriam K. Feldman*

Everybody's doing it. *Lawyers. Professors. Yes, even doctors. Professionals in positions of authority and trust are taking a closer look at how they relate to their clients, students, or patients. Perhaps it all started with Anita Hill, the woman who sounded the wake-up call that was heard around America with the message that sexual harassment, even sexual innuendo, will no longer be tolerated. It's a new day and age. Today, for ethical as well as practical reasons, some bar associations (including Minnesota's) are warning lawyers not to have sex with clients, and many colleges are forbidding professors from getting involved with students. The American Medical Association and state medical boards are also re-evaluating the rules, because in today's climate even something as simple as a pat on the knee can get a physician in trouble.*

"There's a heightened awareness of sexual impropriety now," says Mary Prentnieks, director of legal affairs for the Minnesota Medical Association. "Physicians need to understand that patients are no longer reluctant to address behavior they perceive as sexually offensive. Even the most seemingly innocent behavior may be misperceived by patients as sexual. Patients offended by insensitive behavior may complain to the Board of Medical Practice or seek legal action through the courts. Physicians need to be constantly on guard about how they approach their patients."

Judging by the steadily increasing number of complaints of sexual misconduct or impropriety to the Board of Medical Practice (BMP), Prentnieks is correct. While such complaints are nothing new for the board, the volume and array of complaints have steadily increased since 1985, leveling off at about 90 last year, says H. Leonard Boche, the board's executive director.

Sexual impropriety will be the issue of the '90s for state medical boards, predicted the *Journal of Medical Licensure and Discipline* in its summer 1993 issue, which was devoted to the topic of sexual misconduct. The journal, published by the Federation of State Medical Boards of the United States, noted that sexual intimacy with patients is far more widespread than previously thought. (According to the most often cited statistic, 10 percent of physicians say they have had sexual contact with a patient.) The journal also predicted that state medical boards will be taking more actions against doctors who are guilty of sexual misconduct.

There's a good news-bad news twist to all of this, however. If the bad news is that complaints of sexual misconduct and impropriety have been on the rise, the good news is that, at least in Minnesota, almost all such complaints are related to what the board refers to as "boundary communication issues," rather than actual sexual misconduct, in which a physician has had a sexual or romantic relationship with a patient. These so-called boundary communication issues are something that can be prevented with proper education, says Robert Leach, supervisor of the BMP's complaint review unit.

A typical complaint to the board might come from a woman patient whose doctor put his arm around her shoulder or placed his hand on her knee. The patient believed the doctor was making sexual advances, while the doctor believed he was merely using a warm, caring approach in his practice.

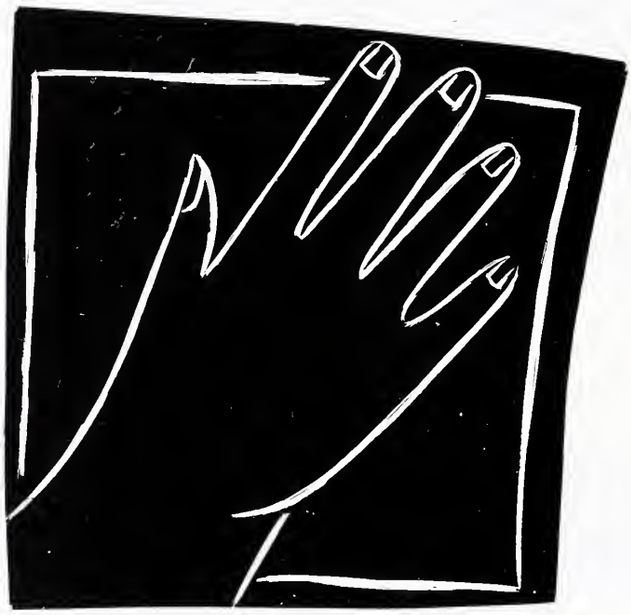
In an effort to head off such misunderstandings, the board (with support from the MMA and Midwest Medical Insurance Company) offered a number of boundaries and communication seminars throughout the state

last fall. "We wanted to tell physicians, 'Physicians need to stop and think about what they're saying and what they're doing, then they won't get into trouble with the patient and with the board,' " Leach explains.

Increasing Concern

Medical practice boards are not alone in their concern about sexual misconduct. The American Medical Association issued its first opinion on sexual relations with patients in the November 20, 1991, issue of *JAMA*, when it stated that sexual contact or romantic involvement concurrent with the physician-patient relationship is unethical. The AMA's Council on Ethical and Judicial Affairs also said that relationships with former patients are unethical under certain circumstances.

In a sign that this matter has taken on even more urgency, the AMA Board of Trustees, at the association's annual December meeting, called for a re-examination of the 1991 opinion because of what it termed the "considerable interest" that has resurfaced concerning the problem. The board set forth a lengthy agenda, in which it called on the AMA to convene a task force, enhance education, and conduct a number of surveys regarding sexual misconduct in the practice of medicine. (The MMA Committee on Ethics and Medical-Legal Affairs also plans to address the issue of sexual misconduct this year, but it will leave the full-scale work to the AMA.)



Medical specialty groups, such as the American College of Obstetricians and Gynecologists (ACOG), are also taking a closer look at the rising number of complaints against physicians. Attributing many complaints to misunderstandings, ACOG plans to publish an educational pamphlet for patients explaining what breast and vaginal exams entail. The group will also try to increase doctors' awareness of communication and boundary problems, says Edward Maeder Jr., M.D., an ob/gyn at Park Nicollet Medical Center in St. Louis Park and chair of ACOG's sixth district.

Many observers attribute the rise in sexual misconduct complaints to society's changing norms. "I think physicians need to recognize that the climate and their patients are very different from what they were even five to 10 years ago," says Elizabeth Lincoln, vice president of risk management for Midwest Medical Insurance Company, a physician-owned professional liability insurance carrier. A greater awareness of sexual harassment, greater publicity about related incidents, and different attitudes toward physicians are all signs of the times, she says. "Patients are approaching physicians very differently. Patients still highly respect physicians, but they expect a level of respect in return. Part of that respect is in how physicians approach patients' bodies."

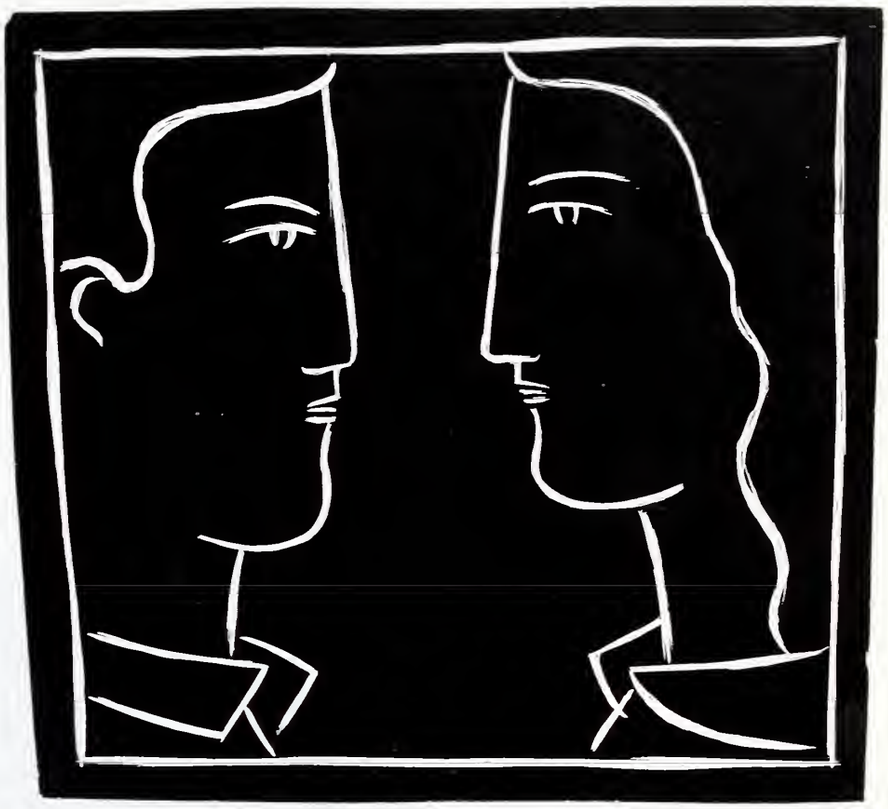
Boche would agree. "There is a lower tolerance to sexually insensitive or inappropriate behavior on the part of licensees," he says. "At one point, the assumption was that the doctor was always right, that the patient had little or no reason to question. That tendency to put the physician on a pedestal has eroded. With greater participation on the part of patients, the physician is questioned."

Patients are questioning all sorts of things, from a physician's failure to provide gowns, to a failure to knock before entering an exam room. Some physicians have been known to help a patient undress or even unhook a bra after deciding abruptly to do a breast exam. These actions leave some patients feeling demeaned or even assaulted, while the physician is unaware that he or she has breached a boundary. "Frequently, it's a matter of the physician being too busy, of not stopping to think about how an action might be perceived by the patient," Lincoln says.

Other troublesome behaviors include improper touch during an exam, inappropriate sexual comments, and inappropriate pelvic exams. Even something as seemingly innocuous as giving a friend a few drug samples for a minor ailment may be sufficient to establish a physician-patient relationship, making the physician vulnerable to charges of sexual misconduct under the Medical Practice Act. Since there is no statute of limitations under the Medical Practice Act, such actions can come back to haunt a physician years later.

Types of Sexual Misconduct

Situations involving sexual misconduct or impropriety typically fall into one of three categories (with the fourth, intentional sexual misconduct, being quite rare), according to a number of sources. One category involves "the seductive patient." This patient either deliberately or unconsciously breaches the boundaries with a physician by expressing too much interest in the physician's personal life. Seductive patients (men or women) tend to ask for service above and beyond what normally should be expected. They may, for example, always ask for the last appointment of the day, request house calls, and tend to get more and more involved in the physician's life. This becomes a problem if the physician falls for the seduction, thus breaching professional boundaries. "Physicians need to recognize when it's happening, and they need to get help with how to address it," Lincoln advises. Colleagues can be good resources, she says, and in some cases, the professional relationship with the patient may have to be terminated.



A second category involves the physician whose intent and technique are entirely appropriate, but a communication breakdown causes a problem—or what the patient perceives as a problem. Typical claims involve breast exams, in which a woman comes in with a swollen ankle, for example, and ends up getting a breast exam after the physician notes that she hasn't had one in more than a year. This most often happens when physicians are busy and don't stop to explain why a particular exam is necessary or appropriate. "So it really is a communication breakdown or misunderstanding," Lincoln says.

In the third category, the intent is appropriate, but the medical technique may be questionable. To safeguard against this type of complaint, which often arises with pelvic and breast exams, Lincoln suggests that physicians ask themselves: Is this a technique recognized by the rest of the professional community? Is this the type of exam typically performed by the specialty, or should I make a referral?

Complaints against physicians may end up before the Board of Medical Practice or in court as malpractice or criminal lawsuits. A complaint to the medical board may result in any number of actions, including a stipulation on the license that the physician receive training or counseling or attend periodic meetings with a designated board member.

Physician Boundaries

Since 1987, the medical board has referred more than 20 physicians from a variety of specialties to John H. Hung, Ph.D., L.P., a clinical psychologist at the University of Minnesota Hospital and Clinic and a recognized authority on the problem of physician-patient boundary violations.

"Anytime we talk about boundaries, the term 'role' comes to mind," says Hung. "So when you have the role of physician, there are certain boundaries that go with that role. One of the guidelines I use is to think through what it means to have the professional role of being a physician. You enter a contract with a patient. You're promising to render the best medical care you're capable of offering ... and to do it in an objective manner. If you enter into some other relationship that compromises that objectivity, you have then not really fulfilled your contract with the patient."

Relationships don't have to be sexual in nature to compromise objectivity, Hung explains. For example, a physician who makes house calls may buy some groceries for an elderly patient who lives by herself and isn't

eating well. She reimburses the physician for the food, and the physician thinks, "What's the harm?"

Potentially plenty, says Hung, who suggests playing out the situation. In this case, Hung imagined that sometime down the road the patient dies, leaving the physician a sizable amount of money in her will. "From a risk management standpoint, you have a problem," says Hung. The family may say that the doctor influenced the person. They may take him to court. "Doctor, do you always buy groceries for your patients?" the lawyers will ask.

"They're going to turn it around and make it sound terrible," Hung says. Even if you say you plan to donate the money to charity, which charity are you going to choose? Your intentions are honorable, says Hung, but you have to think the situation through to the end.

Hung played out another situation involving a patient who is distressed for financial, not physical, reasons. He's just been laid off work and has started drinking. He can't afford to pay his medical bill, and the doctor tells him to pay when he can, which may even be standard practice. Then the doctor offers to loan the patient $50. That's when it's time for the physician to stand back and say: "Why am I doing this? Is this going to put me in a different kind of relationship with this patient that down the road will be problematic?" The answer, Hung says, could be yes. He envisioned this scenario: The patient's alcohol problem gets out of hand. The physician advises him to enter a treatment program. The patient says, "I know why you're doing this; you just want me to pay you back." The doctor had not been looking for a payback, yet, because he was overly involved with the patient, because he had crossed a boundary, he had compromised his credibility as a physician. The patient could no longer trust that his advice was purely medical.

Hung also tells physicians to avoid giving advice that's not of a medical nature, such as money management advice. "Because it's coming from someone wearing a white coat, it carries more weight than it should," he explains. "You're not an accountant; you're not a financial planner."

At the same time, a physician shouldn't turn to a stockbroker patient for financial advice. This establishes a financial-fiduciary relationship with the patient, and later, if things don't go well, the patient may be reluctant to come for treatment, or may question the prescribed treatment. "That's an example of how a relationship that is not romantic can still interfere with the effectiveness of the physician in providing care," Hung says. This doesn't mean that a physician can never buy groceries for a patient or offer financial support. Physicians must weigh the circumstances. "When you look at ethics, it's never black and white."

These concerns take on special importance for small-town physicians, who may be treating everyone in town, from their neighbors, to their ministers, to their children's teachers. Playing other roles, dual roles, with these people is almost unavoidable, Hung says. "And anytime you have a dual relationship, there's a boundary violation, and you need to weigh the consequences."

An unmarried small-town physician has the added problem of avoiding sexual or romantic entanglements with patients, or else risk violating the Minnesota Medical Practice Act. In such situations, chronology is important, says Hung, who believes it is "totally unacceptable" for a physician to ask a patient on a date. On the other hand, a physician will have to consider the propriety of taking on as a patient a person he or she has dated in the past. In that case, he or she may want to consider the proximity of the next closest physician, the nature of the medical problem, and how the former relationship affects objectivity, Hung says.

It is important to note that the BMP's Boche sees no ambiguity in physician-patient dating. If physicians in small towns are going to date, he says, "they'd better date somebody in another town." Similarly, there are proscriptions against treating family members, he says. "We advise doctors not to treat their family members because there's a loss of objectivity, plus there very often isn't a medical record kept. We think it's better medicine and better health care if physicians don't treat their family

members." (The AMA also issued an opinion last June advising physicians against treating family members because their professional objectivity may be compromised.)

"You don't want to do anything to compromise your objectivity," says Hung, who suggests that physicians pay attention to red flags. "Anytime you are considering deviating from standard procedure, ask 'Why?' If you're thinking, 'Maybe I'll meet this patient for coffee,' ask 'Why? I normally don't meet my patients for coffee. Why am I willing to meet this one?' " These questions take on added significance in today's climate, where, as Hung puts it, even Marcus Welby would get into trouble. "The old Marcus Welby would have swung by the grocery store because that's part of doctoring," he says. Today, he'd have to think twice.

Physicians Uneasy

All this may have physicians a little on edge, maybe even paranoid, but Gary Schoener, L.P., who talks about "the myth of the false complaint," insists that nobody's out to get doctors. "If there's a fear physicians have that I have encountered, it is that they're going to be a victim of a false allegation and lose their license," says Schoener, who is a clinical psychologist and executive director of the Walk-In Counseling Center in Minneapolis, a nonprofit center that has worked with victimized patients and with physicians who have experienced boundary issues. Schoener, who has been a consultant to the AMA and several Canadian medical boards, has interviewed thousands of patients and hundreds of practitioners for general purposes, as well as for lawsuits. He acknowledges that while a miscarriage of justice is always possible, it is rare.

The legal process is not stacked in the patient's favor, he says, explaining that the burden of proof is on the patient. What's more, the medical board normally doesn't act on a single complaint. "A single case has to be damned convincing to bring about an action by a board. It's very hard to convict someone in criminal court, especially a doctor for touching the body. The doctor gets the benefit of the doubt."

Nevertheless, Park Nicollet's Maeder says the current atmosphere is making physicians uneasy. "My concern is that this will interfere with appropriate medical care for women," says Maeder. "It makes it tougher to practice medicine."

What's a Physician to Do?

Physicians have to be more sensitive to prevailing norms, says Schoener. "I would tell you today that physically touching a patient who doesn't bristle at the touch is not typically going to lead to trouble, if it's a pat on the arm or leading someone by the elbow. That is not objectionable to most people. But it is more objectionable today or more likely to lead to a concern now than it would have previously. In the old days, things bothered women, but they didn't say anything." MM

Miriam Feldman is a Minneapolis free-lance writer and a frequent contributor to Minnesota Medicine.

Selected Readings

The state medical board asked John H. Hung, a clinical psychologist affiliated with University of Minnesota Hospital and Clinic, in 1987 to develop a "boundaries training" course for a physician who had violated professional boundaries and had become sexually involved with a patient. Hung, who also has a private practice, developed a one-on-one training program using readings, case review and supervision, and discussion. Since that time, Hung has worked with more than 20 physicians from a number of specialties, tailoring his course to the individual. What follows are some suggested readings on professional boundaries in the physician-patient relationship, prepared by Hung for *Minnesota Medicine* readers:

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Why Reform the Health Care System?

This first in a series of articles analyzes why health system reform is being implemented and reviews the Minnesota experience.

Janet L. Silversmith and Kristen Gloege

The health system reform debate has become inescapable. In fact, it is difficult to remember discourse that did not include the topic of health reform. State and federal action on this issue continue, too rapidly for some and too slowly for others. Nevertheless, many significant changes are proposed, are likely to occur, and have already occurred, which can make it difficult to stay abreast of emerging issues—and even more difficult to develop and maintain a comprehensive picture of reform.

To help bring our readers up to date and keep them there, *Minnesota Medicine* will be publishing periodic reports on health system reform issues, both in Minnesota and the nation. The first in this series gets back to the basics—why is the system being reformed, and what is Minnesota doing?

Why Is Health Reform Occurring?

Many people support certain aspects of our current health care system, but there is also strong sentiment that some things must be changed. The priorities and approaches may differ depending on whom you ask, but consensus holds that the principal reasons for reforming our health care system are to increase access, contain costs, and improve quality.

Access

Increasing access to health care is a complex goal that encompasses financial and non-financial barriers to care, such as transportation and language translation. Efforts to provide insurance coverage to the uninsured and underinsured populations address this first goal. An estimated 37 million Americans lack health insurance. Many people believe the uninsured are poor and unemployed; however, nearly 86 percent of Americans without health insurance are full-time workers and their families.[1] In Minnesota, based on 1990 research commissioned by the Minnesota Health Care Access Commission, an estimated 280,000 people (6.5 percent of the population) are uninsured at any given point in time; nearly 370,000 Minnesotans (8.6 percent) are uninsured at some time each year. In addition to the ethical dilemma created when segments of society are without health care coverage, significant problems occur in the system, including cost shifting and higher costs because patients are less likely to receive appropriate and timely care.

Costs

The United States spent approximately 14 percent of its gross domestic product (GDP) on health care in 1992; that is one of every seven dollars in the economy.[2] The Office of Management and Budget has predicted that, at current rates, health care expenditures will reach 19 percent of GDP by the year 2000. Compared with other countries, the United States ranks first in per capita spending on health care, but it is the only industrialized nation that does not guarantee coverage. High health care costs are also considered harmful to U.S. economic competitiveness. In 1990, the average employer paid more than $3,100 for each employee's medical care. U.S. auto makers spend more on health care than they do on steel.[3] Individuals and small employers may also feel the effects of increasing costs in the form of higher premiums or lower wages.

Minnesota's health care costs are difficult to quantify. The Health Care Financing Administration (HCFA) estimates state expenditures only periodically, and Minnesota does not currently have expenditure data for the entire state health care system. Extrapolating national data, Lewin/ICF (a national health consulting firm) estimated Minnesota health expenditures at $14 billion for 1991.[4]

The Congressional Budget Office estimated that the average annual growth rate in national health expenditures between 1985 and 1990 was 9.5 percent. According to the Minnesota Department of Health, Minnesota growth rates are at an estimated 10 percent per year. The University of Minnesota estimates an average per capita increase during 1981 to 1985 of 8.6 percent.[4] Recent reports have indicated that increases in national medical care costs (based on the consumer price index for urban consumers) may be moderating. For 1993, medical care

costs rose 5.4 percent, a marked slowdown compared with the 8.6 percent increase in 1990.[5] Many analysts have speculated that the slowdown may be attributed to the fear of reform. Others have noted that despite the improvement, the increase was still twice the 2.7 percent consumer price index for urban areas for all items.

Numerous factors contribute to the increasing costs of health care: high-cost technological advancements, societal demand for services, over-utilization and inappropriate delivery of care, expensive disease treatments, a litigious environment, an aging population, and administrative inefficiencies.

Quality

Despite high per capita expenditures for health care, the United States ranks comparatively low on several health measures. The United States ranks 21st of 24 industrialized countries in infant mortality rates, 17th for male life expectancy, and 16th for female life expectancy.[6] Statistics such as these, together with our high and increasing costs, have prompted many employers and purchasers of care to demand that providers and health plans prove the value of the health care services they provide. In an effort to meet such demands, providers and health plans have begun the enormous task of collecting data on performance and outcomes. Quality indicators, in the form of report cards, are key elements in both the Minnesota and federal reform plans. All purchasers of care would have access to a variety of data on the outcomes and performance of providers and hospitals. Based on this quality

Deciphering Health Reform Jargon

Capitation: A method of reimbursement in which organizations and/or providers receive a fixed per-member-per-month premium for each enrollee. The entity assumes the risk that the revenue stream will cover the costs for whatever health care services the enrollees need.

Community rating: Setting health insurance premiums on the basis of the average cost of paying for health care services for all people in a defined community, regardless of age, sex, geographic area, or health status. The definition of "community" has significant impact on the effects of the policy. The Minnesota Health Care Commission, for example, defines the community as individuals purchasing an identical product within the same carrier. Modified community rating would allow insurers to adjust for certain characteristics such as age, sex, or geographic area, but not for lifestyle or health status variables. Community rating allows risk to be spread across the entire population, so the healthy subsidize the unhealthy.

Cost shifting: Increasing the charges to one group of patients (such as private pay patients) when the payment for another group of patients will not cover the costs for that group. Primary method of paying for indigent care in the United States and, some say, primary cause of health insurance inflation.

Employer mandate: Requires employers to provide coverage or face stiff penalties. Nixon advocated it in the 1970s. Hawaii implemented it in 1974 (see play or pay).

Global budgets: A limit or cap at either state or federal level on total health care spending for a given unit of population, taking into account all sources of funds. Designed to force providers, patients, and payers to cut costs and make hard choices. Caps could be on employers, total expenditures, individual expenditures, institutional budgets, or on personal out-of-pocket expenditures.

Health insurance purchasing cooperatives (or purchasing pools/alliances): An organization that groups individuals, small businesses, self-employed persons, and others who have difficulty obtaining insurance to serve as the purchasing agent for all members. Better insurance ratings and discounts are anticipated by giving individuals and small businesses the buying power they currently lack and by spreading risk over a large population. Minnesota began the Private Employer Insurance Program (PEIP) in July 1993 to allow employers to purchase health coverage through a larger group.

Integrated service networks (ISNs): Minnesota's version of an accountable health plan, an organization that integrates health care delivery and insurance functions. ISNs will usually consist of a group of physicians, a hospital, and a health plan that will provide a full spectrum of health care services for a predetermined rate and will be accountable for the costs and outcomes associated with the delivery of care to the enrollees.

Jackson Hole Group: An informal group of health reform scholars who meet periodically at the Jackson Hole, Wyoming, home of Paul Ellwood, M.D. (founder of Interstudy, the Minneapolis-based think tank). Constant participants in these discussions are Paul Ellwood, Stanford economist Alain Enthoven, and Lynn Etheredge, a Washington, D.C.-based consultant. The group gained national attention with the 1991 release of a report on health reform through managed competition (upon which the federal reform proposal and a majority of state reform measures are based).

Managed care: Any arrangement for health care in which someone is interposed between the patient

information and the price of services, it is argued, consumers will make more informed decisions, thereby stimulating competition.

Minnesota's Approach to Reform

The Minnesota Legislature began to pay serious attention to the health care system during the 1989 legislative session. In particular, the Legislature focused on the problems of the uninsured and the resultant impact on the system as a whole, e.g., uncompensated care and cost shifting. Legislation failed that would have required every Minnesotan to have health coverage by July 1990, and which would have provided a state-run health program financed by a payroll tax for those unable to pay. Instead, the Legislature created the Minnesota Health Care Access Commission to develop a plan to provide health care access for all state residents. The commission, in existence for two years, included 15 public members appointed by the governor representing consumers, providers, businesses, insurers, and unions, as well as representatives of the departments of Health, Human Services, and Employee Relations.

During the 1990 legislative session, a bill was introduced that called for a constitutional amendment guaranteeing affordable health insurance for all Minnesotans. The bill did not receive a committee hearing and, therefore, was never pursued.

The Minnesota Health Care Access Commission, through original research, public hearings, and group deliberations, developed a set of final recommendations

and physician and has authority to place restraints on how and from whom the patient may obtain medical and health services, and what services are to be provided in a given situation. The term is most often applied to health maintenance organizations (HMOs), preferred provider organizations (PPOs), and independent practice associations (IPAs); however, it may also apply to indemnity insurers with utilization review.

Managed competition: A strategy for purchasing health care in a manner that will obtain maximum value for the price for the purchasers of the health care and the recipients. The aim is to expand access and control costs by encouraging market forces between competing networks of providers. Concept was primarily developed by Stanford economist Alain Enthoven and the Jackson Hole Group.

Managed competition II: The new approach to reform being advanced by the Jackson Hole Group, the original creators of the managed competition concept. The second version of the concept recommends enacting reform in stages. Initially, individuals at 100 percent of the poverty level would be covered. Two to three years later, people at 200 percent of the poverty level would be covered. During this time, Paul Ellwood argues, the government should study the situation; also, voluntary and competing purchasing cooperatives would be established, and a combination of employer and individual mandates would be introduced. Employees working in firms with fewer than 100 employees would be subject to an individual mandate; firms with more than 100 employees would be subject to the employer mandate.

MinnesotaCare: The term used interchangeably to apply to the program created in 1992 for the uninsured, as well as to Minnesota's reform efforts initiated in 1992 and amended by the 1993 Legislature.

Play or pay: A health reform proposal that would require employers to provide health care coverage for their employees (play) or pay into a government-subsidized plan (pay). The subsidized plan would be used to provide coverage for the employed uninsured and the unemployed.

Point-of-service option (POS): A health care plan that allows the enrollee to select a health care provider each time he or she needs medical care, rather than once a year.

Portability: A term applied to health insurance benefits that would allow workers to keep the same insurance policy when they change or lose a job.

Regulated all-payer option (RAPO): The payment mechanism envisioned in Minnesota for all health care services delivered outside an ISN. The system is expected to be designed to control costs, prices, and utilization of non-ISN health care services. Reimbursement to providers in this system is expected to be based on Medicare's Resource-Based Relative Value Scale (RBRVS).

Single payer: A system in which one entity (usually the government) is responsible for administering and financing health care service delivery, including negotiating provider rates and coverage for the insured. The system is usually funded out of tax revenue, rather than premiums, and is used to pay for health care expenditures. Generally, hospitals and physicians remain private, and individuals have the freedom to choose their own providers.

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to the 1991 Legislature to ensure universal access to health care for all Minnesotans. Its two primary recommendations were:

1) Ensure access to needed health care for all Minnesotans by requiring all state residents to have coverage, providing a subsidized program to persons below 275 percent of the poverty level, implementing insurance reforms in individual and small group markets, and providing a universal, basic benefits set to all members of society.

2) Manage health care costs by implementing limits on statewide health care spending; producing an environment that allows management of care, not shifting of costs; developing standardized administrative processes;

States to watch

Colorado: ColoradoCare (public insurance program for low-income residents); single-payer plan being introduced; insurance reforms and Medicaid managed care program; emphasis on cost containment, universal health insurance, purchasing alliances.

Florida: Managed competition model*; voluntary community health purchasing alliances; Med-Access and Medicaid buy-in programs; Medi-Pass; Medicaid managed care program; insurance reforms.

Kentucky: Insurance reform; malpractice insurance; provider tax; purchasing alliances; play-or-pay and single-payer plans proposed; Medicaid managed care program. Controversial provider tax could delay action on other health care measures.

Minnesota: Managed competition; insurance reform; Medicaid managed care program; integrated service networks forming following passage of health reform legislation in 1992 and 1993; expenditure limits to control growth rate of health costs; data collection body and a framework for controlling the spread of technology.

Missouri: Managed competition proposal; insurance reform (community rating, 30-day open enrollment periods, and standardized benefits packages); exclusive purchasing cooperatives; creation of health care regions; Medicaid managed care program.

Montana: Single-payer and multi-payer plans proposed; insurance reform; Medicaid managed care program; emphasis on universal access and global budgets.

New York: Single-payer proposal; some insurance reform with one of strongest community rating laws; Medicaid managed care program; uniform pricing expanded to ambulatory care centers, emergency centers, clinics, and ambulatory surgery centers.

Ohio: Insurance reform; managed care and managed competition for Medicaid program as base for future reform.

Oklahoma: Insurance reform; individual/family health accounts; Medicaid managed care program.

Pennsylvania: Central governing authority; guaranteed benefits; purchasing networks; managed competition proposal; Medicaid managed care program.

Tennessee: Insurance reform; Medicaid managed care program emphasizing global budgeting; capitated managed care delivery system; preventive care and cost sharing based on ability to pay.

Vermont: Single-payer and multi-payer proposals; employer and individual mandates; insurance reform; Medicaid managed care program not yet implemented.

Washington: Universal access; managed competition and premium caps; employer mandate; some insurance reform; Medicaid managed care program.

West Virginia: Reconsidering West Virginia Health Care Act of 1993. The act aims to expand access and contain costs by reducing administrative expenses, better integrating existing state services, and promoting formation of networks through provider reimbursement. Also includes insurance reform and a Medicaid managed care program.

Wisconsin: Single-payer and managed competition plans proposed; voluntary purchasing alliances; insurance reform (portable policies, guaranteed issue and modified community rating, rate bands on pre-existing conditions limited, and rate bands by occupation prohibited); Medicaid managed care program.

*Florida is being hailed as the model for the Jackson Hole approach to managed competition.

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controlling costs through managed care organizations; consolidating state health care programs; conducting research and data collection on health delivery and outcomes; establishing a reinsurance pool for high-cost cases; emphasizing preventive care and early interventions in development of a standard benefits set; encouraging patient responsibility; and promoting competition to allow consumer choice.

Based on the commission's recommendations, numerous bills were introduced during the 1991 legislative session, including a plan from Gov. Arne Carlson that proposed establishing a pilot project for the uninsured, a small employer health plan, a committee to analyze the cost-effectiveness of new technology, and an office of rural health. The DFL legislators also introduced a bill (House File 2) that would have required coverage of all Minnesotans. The governor vetoed House File 2, and no comprehensive health care legislation passed during 1991.

During 1992, a bipartisan group of legislators (the "Gang of Seven") began meeting to draft a health care bill. The bipartisan coalition created the legislation known initially as HealthRight, which, in part, established the Minnesota Health Care Commission (MHCC), created a phase-out timeline for balance billing Medicare patients, identified the MMA as the organization that would provide educational peer review to physicians whose practices deviate from medically appropriate practice parameters, initiated insurance reform provisions, created a funding mechanism (2 percent health services tax, 5-cent cigarette tax increase, and 1 percent HMO tax), outlined cost-containment goals, and established a subsidized health insurance program for low-income and uninsured persons (now known as the MinnesotaCare program).

The MHCC was initially charged with the complex task of developing a cost-containment plan that would slow the rate of growth in health care spending by at least 10 percent per year for the next five years (through 1998). The commission's report, delivered to the Legislature and the governor in January 1993, outlined the direction of Minnesota's reform plans. The cost-containment plan, as approved by the 1993 Legislature, included an annual limit on the rate of growth in health care spending and implemented programs to achieve compliance with the limits. The cost-containment plan is fairly comprehensive in that it seeks to reduce costs and enhance quality through improvement in the competitive marketplace. The 1993 legislation also established the groundwork for several other important features of the plan, including integrated service networks (ISNs); growth limits; the regulated all-payer option (RAPO); purchasing reform; technology assessment; a system for data collection, analysis, and dissemination; consumer education; and universal coverage. MHCC addressed the details of many of these items in its implementation plan, which was presented to the 1994 Legislature.

Reform Activity in Other States

Knowing the extent of health system reform measures introduced and implemented in other states provides a context for Minnesota's own reform efforts. Some types of changes, such as insurance reform, have occurred to some degree in virtually all states. Other reforms, such as the use of an employer mandate and single-payer legislation, have been applied in only a few states. In addition to some of the incremental reform steps, most states have created commissions and task forces to begin looking at more extensive health reform. While some states are waiting for the development of a national health system reform plan, to avoid making incompatible changes, other states are forging ahead by addressing state-specific needs while tailoring plans to be compatible with the federal proposal. In addition to Minnesota, the states to watch in 1994 include Colorado, Florida, Kentucky, Missouri, Montana, New York, Ohio, Oklahoma, Pennsylvania, Tennessee, Vermont, Washington, West Virginia, and Wisconsin (see table, facing page, for specific information on each of these states).

While there may be fairly broad-based support for the goals of health system reform, disagreement most often occurs over how the goals can best be accomplished. In next month's article, we will provide an overview of some of the options that have been proposed for reforming the system, including Minnesota's version of managed competition—the integrated service network, or ISN, proposal. MM

Janet Silversmith and Kristen Gloege are health policy analysts for the Minnesota Medical Association.

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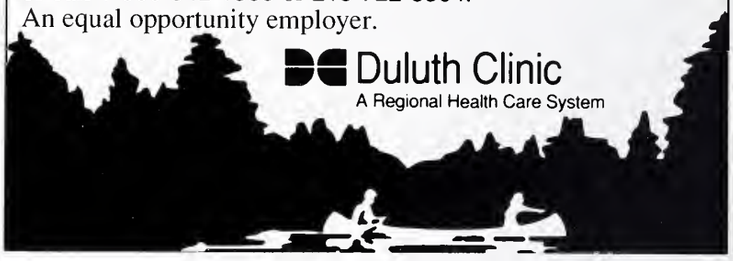

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Primary physicians should be sure their women patients of all ages are being screened for cervical cancer. Underinsured women with low incomes may be referred to the Minnesota Breast and Cervical Cancer Control Program for free exams.

Jonathan S. Slater, Ph.D., Annette Bar-Cohen, M.A., M.P.H., Jane E. Korn, M.D., M.P.H., and Barbara Yawn, M.D., M.S.

Editor's Note: *This is the first article in a series of eight public health articles to appear in* Minnesota Medicine *during the next two years. Topics chosen will be of relevance to practicing physicians in Minnesota. Each article will be short, combining epidemiological data with information important to your practice. I look forward to your comments and suggestions for modifications of the format and future topics.*

–Barbara P. Yawn, M.D., M.S., series editor

Despite the dramatic decline in cervical cancer mortality associated with widespread use of the Papanicolaou smear, survival rates for cervical cancer have not improved since the 1970s.[1] Even though older women remain vulnerable to this disease, cervical cancer screening rates decline with age. Survey data from the National Cancer Institute show that approximately 85 percent of women 18 to 39 years of age have had a Pap smear in the past three years,[2] and, according to unpublished data from T. Kottke (March 1994), a recent population-based survey in southeast Minnesota showed that at least 87 percent of women under age 40 have had a Pap test in the past two years. However, the National Cancer Institute data show that only 61.6 percent of women aged 60 to 69 were screened in the past three years; 76 percent of women in southeast Minnesota in this age group report having a Pap smear in the past two years. It is unclear to what extent hysterectomy may account for lower Pap rates among older women. Because cervical cancer mortality is nearly entirely preventable, primary care physicians can play a crucial role in reversing this trend, especially among women over age 50 who may no longer get regular gynecologic care.

Early Detection of Cervical Cancer

Cervical cancer is often considered a cancer of younger women. And while it's true the number of cases diagnosed is highest in women aged 25 to 45, the rate of newly diagnosed cases (incidence rate) begins to climb for women in their mid-20s and never decreases (see figure). The woman who lives to age 70 has a greater chance of developing cervical cancer in her next decade of life than the low-risk woman in her 20s, 30s, 40s, or 50s. Therefore, older women whose life expectancy is greater than three to five years and whose quality of life would be improved by detection and treatment of cervical cancer need to continue to have Pap smears. Age alone is not an indication to discontinue screening.

The fact that cervical cancer mortality rates are inversely related to screening utilization illustrates the importance of regular screening. Nationally, about 60 percent of invasive cervical cancers occur in women who have not had a recent Pap smear.[3] In Minnesota, half the women diagnosed with cervical cancer are over age 44, which is not surprising given their lower screening rates.[4] Older women, women of color, and women with incomes less than 200 percent of the poverty level have the lowest screening rates and the poorest five-year survival rates.[1]

Barriers to Care

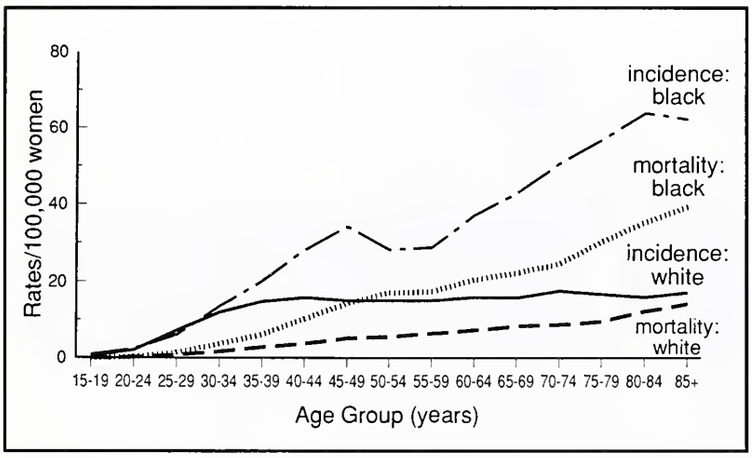
The three most common reasons women report for not having a Pap smear are lack of physician recommendation, perceived lack of personal risk, and cost of the procedure.[2] Physicians have numerous opportunities to recommend Pap smears and to help women recognize their personal risk of cervical cancer. Many easy, inexpensive office systems have been developed for providers to remind women about cervical cancer screening, such as postcard reminders and preventive care flow charts in medical records. Simply remembering to ask for the date of the last Pap smear when obtaining the medical history is also effective.

Pap smear, pelvic examination, and the medical history remain the basic tools to detect cervical cancer. The American Cancer Society and American College of Obstetricians and Gynecologists have developed minimal accepted screening guidelines for low-risk and asymptomatic women. Health care practitioners can improve early detection and treatment rates by routinely asking women to have pelvic examinations and Pap smears according to these guidelines (see table).

Minnesota Breast and Cervical Cancer Control Program

Minnesota is fortunate to have a program to deal with the cost barrier. In 1990, Congress passed the Breast and Cervical Cancer Mortality Prevention Act. The Minnesota Department of Health (MDH) was one of the first four state health departments funded to develop and implement a comprehensive breast and cervical cancer control program. Unlike many similar federal programs, this one was designed to pay for patient care. Over the past two years, the MDH's Cancer Control Section has established a network of more than 130 screening sites as part of the Minnesota Breast and Cervical Cancer Control Program (MBCCCP). Among the sites participating are a substantial number of private physician offices. Underinsured and uninsured women whose incomes fall within generous guidelines (250 percent of the federal poverty level) are eligible to receive free breast examinations, mammograms, pelvic exams, Pap smears, and, when necessary, colposcopy. MBCCCP has developed a tracking and follow-up system to assure that women with abnormal test results receive appropriate follow-up and treatment.

More than 26,000 women have been screened to date. Four invasive cervical cancers and 454 biopsy-confirmed CIN2 or CIN3 lesions have been detected. More than 900 women enrolled in the program have received treatment for cervical abnormalities, and only 0.8 percent of women screened have been lost to follow-up.



Figure–Average annual age-specific cervical cancer SEER* incidence and U.S. mortality rates, by race, 1983-1987.

* SEER=Surveillance, Epidemiology, End Results Program, National Cancer Institute.

Source: Qualters JR, Lee NC, Smith RA, Aubert RE. Breast and cervical cancer surveillance, United States, 1973-1987. MMWR 1992;41(SS-2):13.

Table

Guidelines for cervical cancer screening (for asymptomatic, low-risk women)

American Cancer Society and American College of Obstetricians and Gynecologists

- Annual Pap smear beginning at age 18 (or onset of sexual activity, if earlier)
- After three consecutive negative Paps, may decrease to every 2-3 years at physician's discretion
- Continue throughout lifetime

Cervical cancer risk factors

- Early age at first intercourse
- Greater number of sexual partners
- Greater number of sexual partners of partner
- Human papilloma virus (types 16 and 18)
- History of venereal disease
- Smoking
- Low socioeconomic status

Summary

Cervical cancer remains an uncommon but fatal cancer for women in all age groups. As women leave the reproductive years and increasingly receive care from specialists, screening rates decline. By ensuring that your patients continue to get regular Pap smears throughout their lives, you can help prevent morbidity and even mortality from cervical cancer. For patients unable to afford screening, referral should be made to the nearest MBCCCP site. For locations and other information, call the Cancer Control Section of the Minnesota Department of Health, 612/627-5444, or the American Cancer Society, 800/227-2345. MM

Jonathan Slater is chief of the Cancer Control Section at the Minnesota Department of Health. He is program director of the Minnesota Breast and Cervical Cancer Control Program. Annette Bar-Cohen is head of the Education and Coalition Unit of the Cancer Control Section of the Minnesota Department of Health. Jane Korn is head of the Service Delivery Unit of the Cancer Control Section of the Minnesota Department of Health. Barbara Yawn is director of clinical research for the Olmsted Medical Group in Rochester, Minnesota.

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Are Medical Licensing Questions Discriminatory?

A current court case may deem certain questions on medical license applications illegal under the Americans with Disabilities Act.

Margo S. Struthers, J.D., and Laurence M. Ulrich, J.D.

Physicians may be familiar with the impact of the Americans with Disabilities Act (ADA) on their patients, on the physical structure of hospitals and clinics, and even on their own hiring practices.* But what about effects on them, personally? How does the ADA affect physician licensing and the licensing of other health care professionals in Minnesota?

Medical License Litigation

The answer to that question may be influenced by the decisions of a federal judge in New Jersey in a case brought by the Medical Society of New Jersey against the New Jersey State Board of Medical Examiners.[1] In October, the judge issued an opinion suggesting that he would prohibit the board from compelling physicians to answer certain questions on license applications and renewal applications.† The Medical Society of New Jersey claims that certain questions unlawfully inquire into the existence of disabilities and that licensing decisions based on affirmative answers constitute disability discrimination.

The New Jersey Medical Application

The challenged questions on the New Jersey application are:

- Have you ever been dependent on alcohol or controlled dangerous substances?
- Have you ever been treated for alcohol or drug abuse?
- Have you ever suffered or been treated for any mental illness or psychiatric problems?
- Do you have any uncorrected physical handicap that causes substantial impairment of, or limitation on, your ability to practice medicine and surgery?

Physicians who answer affirmatively to any of these questions, and similar questions on the New Jersey renewal application, are required to submit to the board a summary of diagnosis, treatment, and prognosis. Applicants cannot avoid responding to these questions without consequence. The application forms require the applicant to certify that the answers are complete and warn that failure to answer any of the questions could result in the denial of a license.

The ADA and Medical Licensing

The court agreed with the medical society that the board was a public entity subject to Title II of the ADA. Title II states that "No qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."

The judge then considered whether the challenged questions and the board's further investigations based on affirmative answers impermissibly discriminate against disabled persons. The ADA defines disability as:

- A physical or mental impairment that substantially limits one or more major life activities;
- A record of such an impairment; or
- Being regarded as having such an impairment.

Accordingly, the ADA protects not only currently disabled persons, but also persons who have recovered from a disability, as well as those who are merely perceived (correctly or incorrectly) as having a disability. Regulations promulgated under the ADA include within the term "physical or mental impairment" a wide variety of conditions, including drug addiction and alcoholism. With that as a basis, the judge concluded that each of the challenged questions inquires into disabilities because they

* See also Burke FG. Disabilities discrimination in public accommodations and services. Minn Med 1991;74(11):29.

† The court's opinion accompanied its order denying the medical society's motion to restrain the board from asking or acting upon the disputed questions during the lawsuit. Although the judge denied the medical society's motion, he discussed at length the merits of the claim, giving a strong indication of how he would ultimately decide.

seek information regarding physical or mental impairments and alcohol or drug abuse.

That, however, does not conclude the inquiry. The ADA does not protect all individuals with disabilities; it only protects qualified individuals with disabilities. Therefore, the critical question is whether persons answering these questions affirmatively are persons who, with or without reasonable modification to rules, policies, or practices, meet the essential eligibility requirements for a medical license. Or, more simply, could a physician diagnosed as mentally ill or chemically dependent be capable of performing the essential functions of a physician? Although the judge gave the board some deference to its opinion on this question because of its experience and knowledge, he reserved final authority to determine what the essential eligibility requirements are for receiving a medical license. He then concluded that many, "if not the vast majority," of the applicants who answer affirmatively to one or more of the challenged questions are nonetheless qualified to hold a license and, therefore, are "qualified individuals with disabilities" protected under Title II.

The Justice Department Position

This case attracted attention from the United States Department of Justice, which weighed in on the side of the medical society. Its fundamental position was that by categorizing persons with disabilities as potentially unfit and imposing additional burdens of investigation on them, the board indulged unwarranted stereotyping of disabled persons.

In support of this reasoning, the Justice Department looked to a federal case from Massachusetts in which the court found that a state law requiring physicians over 70 to pass an annual medical examination violated the federal Age Discrimination in Employment Act (ADEA). In that case, the court reasoned that the purpose of the ADEA was to abandon stereotypes about the abilities and capabilities of older workers and, therefore, age could not be used as a convenient criterion by which to regulate and condition employment. The question should not be whether an applicant is old or disabled but whether he or she can do the job. Because the New Jersey application questions focus on disability rather than ability to do the job, the Justice Department argued that they violate the ADA. It appears that the court agrees. Both the Justice Department and the court pointed to alternative information the board can seek to judge an individual candidate's qualifications, e.g., whether the candidate's hospital privileges have been suspended or revoked or whether a patient has sued for malpractice or filed a complaint.

> "The question is not whether an applicant is old or disabled but whether he or she can do the job."

Attorney License Cases

As noted earlier, the New Jersey opinion is not the final word from the court on this issue. Before the New Jersey judge renders his final decision, he will likely be influenced by other court rulings. For example, last December the Maine Supreme Court issued an opinion granting bar admission to two individuals who refused to answer the following questions on their applications for licenses to practice law:[2]

- Have you ever received a diagnosis of an emotional, nervous, or mental disorder? If so, state the names and addresses of the psychologist, psychiatrist, or other medical practitioners who made such diagnosis.
- Within the 10-year period prior to the date of this application, have you ever received treatment of emotional, nervous, or mental disorder? If so, state the names and complete addresses of each psychologist, psychiatrist, or other health care professional, including social worker, who treated you. (This question does not intend to apply to occasional consultation for conditions of emotional stress or depression, and such consultation should not be reported.)

The applicants also refused to sign the authorization permitting the bar examiners to acquire medical records and interview physicians and other health care providers. The court cited the opinion from the Medical Society of New Jersey case and held that the questions and authorizations were similarly contrary to the ADA.

Although no further opinions have yet been issued, cases against other state boards of bar examiners have been commenced or threatened in Arizona, Connecticut, and Texas. In Minnesota, the deans and certain faculty of all three Minnesota law schools have petitioned the Minnesota State Supreme Court to review mental health questions that are currently being asked on the state Board of Law Examiners' application forms. The Supreme Court is expected to conduct a public hearing in the near future.

Minnesota Medical License Application

How will the ADA, and cases interpreting it, affect licensing in Minnesota? The current Application to Practice Medicine used by the Minnesota Board of Medical Practice (BMP) poses the following questions:

- Are you presently in good physical and mental health? If not, give particulars.
- Have you ever been voluntarily or involuntarily committed to a public or private mental health facility, detoxification center, or chemical dependency treatment facility, or been disabled by accident or physical or mental illness? If so, give particulars and provide medical records.
- Do you now, or have you ever, personally used or administered to yourself any controlled substances, or have you ever been treated for drug or alcohol abuse? If so, give particulars as well as the attending physician's statement.

As with the New Jersey forms, physicians must certify that they have answered the questions "completely, without reservations of any kind."

(Curiously, the renewal license application does not include any inquiries into treatment for medical illness or chemical dependency. Perhaps the BMP assumes that these would be unearthed by the complaint review process and the reporting requirements associated with that process.)

While fine distinctions could be made between Minnesota's questions and those on the New Jersey application forms, it is unlikely that a federal judge in Minnesota would conduct a significantly different analysis than did the New Jersey or Maine judges. In short, current licensing procedures in Minnesota will be subject to the same kind of scrutiny now being applied to licensing procedures elsewhere. If the New Jersey judge, in fact, rules in favor of the medical society, groups in other states, including Minnesota, will be encouraged to challenge their states' licensing practices.

The ADA and BMP Disciplinary Procedures

The same set of concerns over licensing may also affect how the state regulates licensed physicians. Minnesota law provides a number of grounds on which the BMP may impose disciplinary action, including revocation, suspension, or restriction of a physician's practice of medicine. Among the grounds are:

- failure to demonstrate the qualifications or satisfy the requirements for a license;
- adjudication as mentally incompetent, mentally ill, or mentally retarded, or as a chemically dependent person, a person dangerous to the public, or a person who has a psychopathic personality by a court of competent jurisdiction, within or without this state;
- inability to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, use of drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills;
- becoming addicted or habituated to a drug or intoxicant.

If the BMP has probable cause to believe that grounds exist for it to exercise its disciplinary authority, it may direct a physical or mental examination and obtain a physician's medical records without consent. In addition, physicians are under obligation to report, and self-report, to the BMP personal knowledge of any conduct that the physician reasonably believes constitutes grounds for disciplinary action, including the four grounds quoted above.

The grounds for discipline are arguably less comprehensive and, therefore, not as objectionable as the application questions. For example, treatment for mental illness that does not rise to the level of "disability," or chemical dependency treatment that does not involve "commitment," may not have to be reported for disciplinary purposes unless the mental illness or chemical dependency prevents the physician from practicing medicine with reasonable skill and safety. Nevertheless, these issues raise concerns similar to those being litigated in the New Jersey case.

One method to avoid unintended harsh consequences of the reporting requirement is a "diversion" program. As *Minnesota Medicine* went to press, a bill was pending in the Minnesota Legislature (S.F. 1849) that would authorize the professional health licensing boards to jointly engage in a health professionals services program to monitor regulated persons who are unable to practice with reasonable skill and safety due to any physical, mental, or psychological condition. Programs of this kind are an attempt to deal with problems outside the disciplinary process and in a manner that maintains information related to the program as nonpublic. An initial draft of the diversion bill would have authorized the program to oversee the regulation of persons assessed with a substance abuse problem or a mental, physical, or psychological condition regardless of whether they constitute a threat to public health and safety. In response to MMA concerns, this language was modified so that the proposed program would regulate only those persons who are unable to practice with reasonable skill and safety. In line with the Medical Society of New Jersey, the MMA argued that the original language violated Title II of the ADA because the imposition of additional burdens on individuals assessed with a condition that currently poses no threat to public health and safety constitutes discrimination. The bill, in its revised form, was expected to pass.

Conclusion

Currently, none of these Minnesota statutory provisions or board practices has been deemed illegal under the federal ADA or the state law prohibiting discrimination against qualified disabled persons. However, neither have they been challenged. The Board of Medical Practice is not currently planning to revise its application. In fact, the board is under intense media scrutiny for its handling of certain physicians with DWI convictions.

Public concerns over the safety and quality of health care may be on a collision course with the newly enhanced rights of disabled persons. There is no dispute that the public interest served by state licensing requirements and disciplinary procedures must be balanced against the rights of individual practitioners. The critical question after the ADA is whether the current practice strikes that balance. The question is ripe for decision in Minnesota. MM

This article is a general discussion of legal issues and is not intended as legal advice. The general principles discussed here may not apply to a specific legal problem. This article is no substitute for the advice of knowledgeable legal counsel who has reviewed the specific facts and law regarding any given legal matter.

Margo Struthers and Larry Ulrich practice law with Oppenheimer Wolff and Donnelly in Minneapolis.

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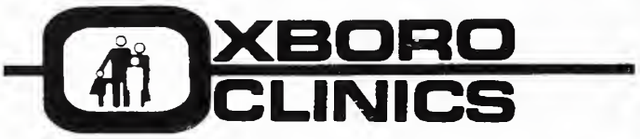

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Negotiating a Practice Sale

When contemplating selling your practice to a hospital, you must consider numerous issues, such as the practice's value, physician employment terms, and employee benefits. Second of two parts.

Forrest G. Burke, J.D.

Across Minnesota and the United States, hospitals are offering to purchase medical practices, and many groups are deciding to sell. However, as the first part of this article discussed, physicians must consider many issues before selling to a hospital (see *Minnesota Medicine*, April 1994, page 44). First, the physician group should review the forces in the marketplace to determine whether integration with a particular hospital will forge a sound strategic alliance. Second, the physicians should carefully consider the structure of the proposed acquisition and the tax ramifications of that structure. Third, the physicians should evaluate the proposed governance of the new structure and their roles in that structure.

In addition to these issues, several other critical factors must be considered in a practice acquisition, including valuation of the medical practice, physician employment terms, and employee benefits.

Medical Practice Valuation

As in all business transactions, the purchase price is usually the center of lengthy and contentious negotiations between the parties. (See also "What Are You Worth? A Management Perspective on Valuing a Medical Practice," *Minnesota Medicine*, August 1993, page 25.) Obviously, the physician group hopes to obtain the highest possible price for the medical practice, while the hospital hopes to minimize its cash outlay. In the context of a hospital acquiring a medical practice, the purchase price is also the subject of numerous legal issues. Because a tax-exempt hospital may not enter into any transaction that results in excessive "private benefit" to an individual or entity, the hospital is, in effect, precluded from paying more than fair market value for a medical practice. In addition to the legal constraints posed by the hospital's tax-exempt status, payment in excess of fair market value may be deemed a payment by the hospital for past or future referrals from the clinic, in violation of the federal Medicare/Medicaid anti-kickback statute.[1]

If the government finds that a hospital overpaid physicians for a medical practice, constituting improper private benefit to the physicians, the Internal Revenue Service could revoke the hospital's tax-exempt status. If excessive payments for a medical practice are deemed to violate the anti-kickback statute, the possible penalties are even more staggering. Because it is a violation of the anti-kickback statute to pay or to receive payment for patient referrals, both the hospital executives and the physicians involved could face criminal felony liability with prison terms of up to five years. In addition, civil penalties for violation of the anti-kickback statute may include large penalties and/or exclusion from the Medicare and Medicaid programs. Because of these potentially devastating sanctions, both hospitals and physicians must take steps to ensure that the purchase price paid for the medical practice reflects the fair market value of the practice and does not compensate physicians for past or future patient referrals to the hospital.

Because both the IRS regulations and the anti-kickback statute suggest that hospitals may only pay fair market value for a medical practice, the logical solution appears deceptively simple: obtain an independent appraisal to establish the fair market value of the practice. In reality, the solution is more complex. Although the use of an appraisal to establish the fair market value of a medical practice is clearly advisable, the IRS and the Office of Inspector General (OIG) do not agree which assets of the medical practice should be included in the valuation.

The IRS has indicated in several recent publications that a standard valuation methodology, which includes reviews of the practice income, market value, and cost, may be used to establish the practice's value. The IRS has specifically indicated that the valuation of practice intangibles (trade name, assembled work force, or other components of goodwill) may be taken into account as part of the valuation. However, the OIG indicated in a letter dated December 22, 1992, issued by D. McCarty Thornton, associate general counsel of the OIG, that any payments in excess of the fair market value of the medical practice's hard

assets may be deemed payments for future referrals. In essence, the OIG's position is that any payment for intangibles may be treated as an unlawful payment for referrals, in which case, it would violate the anti-kickback statute. Thornton has subsequently softened his rhetoric somewhat and has indicated that the OIG does not want to "stand in the way of integration," but the OIG continues to view payments for medical practice intangibles as inherently suspect.

Although the IRS has granted tax exemption to entities involved in medical practice acquisitions when the purchase price included payment for intangibles, those rulings have been specifically conditioned upon compliance with the anti-kickback statute, and the IRS has offered no opinion on whether it considered those transactions to have complied with the anti-kickback statute.

Because the OIG's and the IRS's views are so divergent, the valuation of a medical practice is an absolutely crucial element of transaction, and hospitals and medical groups alike should retain experienced health care lawyers to assist them in consummating these transactions.

Another question to consider is whether a medical practice valuation should be done on a pre-tax or post-tax basis. The IRS has indicated that valuations performed on a pre-tax basis, in effect, transfer the hospital's tax exemption benefits to the physicians. Again, this is another technical and tricky area that calls for experienced legal and financial counsel.

Employment Terms

Because physicians selling their practice face an abrupt change from managing their own offices to becoming part of a larger, integrated health care delivery system, they must carefully scrutinize the terms of employment extended to them. They should review the compensation system with legal and financial counsel and compare it with their existing compensation plans. If the medical practice is being sold directly to a tax-exempt entity, the compensation system is likely to be less tied to the revenue produced by each physician. If the medical practice is being sold to a taxable entity, the physicians may have greater ability to negotiate a compensation system consistent with their current arrangement.

The term of the physicians' employment is another important element. The hospital may ask the physicians for a lengthier employment commitment than the physicians currently have with their medical practice. Terms of five years or longer are not uncommon in a hospital-physician employment relationship. In negotiating an appropriate term, physicians within a medical practice may have diverging viewpoints. The more senior physicians in the group may want a longer term of employment for greater stability with retirement approaching, while younger physicians may want to keep their options open and negotiate for a shorter employment commitment. Generally, hospitals are more likely to pay a premium signing bonus to physician groups that are willing to make a long-term employment commitment in connection with the sale of their medical practice.

> "As in all business transactions, the purchase price is usually the center of lengthy and contentious negotiations between the parties."

Many hospitals will also ask that physicians agree to a noncompetition provision as part of the purchase. These noncompetition agreements often contain a nonsolicitation clause that would prevent the physicians from soliciting their former patients after leaving employment. Physicians should take great care when negotiating noncompetition and nonsolicitation covenants and should only agree to covenants reasonably related to the new employer's legitimate business interests.

While noncompetition arrangements are typical components of a medical practice purchase, the scope and duration vary greatly depending on the circumstances and are often subjects of intense negotiation. On the other hand, if a physician group is selling a medical practice to a large health care system, the buyer may already have an established template for practice acquisitions and will be unwilling to depart from the template because it could create political problems with other physicians who have entered into similar transactions.

The termination provisions of the employment agreement are also of great importance. Typically, the physicians' employment may be terminated "for cause." The definition of "for cause" termination may vary, but it usually includes termination as a result of a physician's loss or restriction of his or her medical license. Numerous other grounds may also be included as a basis for termination, and physicians should carefully review the provisions to ensure that their employment may not be arbitrarily or capriciously terminated.

Physicians should consider numerous other issues in the employment contract. They should make sure the employment agreement specifies to whom the physicians report and on what matters (medical vs. administrative). They should review the employment agreement to determine whether it restricts their ability to engage in "moonlighting activities," and they should also review the contract to determine whether it provides malpractice tail coverage when their employment terminates.

Employee Benefits

The physicians, with the advice of their legal and financial counsel, should carefully review the benefits package offered by the hospital and compare this package with the benefits provided through their medical practice. If the physicians are to be employed by a tax-exempt entity, certain retirement benefits, such as 401(k) plans, may not be available

because of legal constraints imposed on tax-exempt entities. In addition, the contributions made by the tax-exempt entity on behalf of each employee may be limited. Because tax-exempt entities may offer certain benefits that are unavailable to taxable employers, such as 403(b) annuity plans, the benefits plans might compare favorably, but these comparisons vary drastically depending on the circumstances. If significant discrepancies have an adverse impact on the physicians' benefits or retirement planning, the physicians should negotiate appropriate adjustments to either the benefits plans or the compensation system to address the shortcomings.

The physicians should also consider how their own employees will be affected by the acquisition. The treatment of staff and their benefits is often a subject of significant negotiation.

The issues discussed above are just a few of the many that a physician group should contemplate if it is considering selling its practice to a hospital. Given the large number of issues to be addressed and their complexity, physician groups should diligently compare their current situations with the hospital's proposal before making a decision to integrate. MM

The preceding general discussion is designed to alert physicians to legal issues that arise in the sale of a medical practice. It is not legal advice and should not be relied upon as such.

Forrest Burke is a member of Dorsey & Whitney's Health Practice Group in Minneapolis and specializes in health care mergers and acquisitions and joint ventures.

REFERENCE

1. 42 U.S.C. § 320a-7b(b).

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FISCH

(continued from page 7)

and Fisch's patients are its beneficiaries. Patricia Mielke met Fisch in July 1990, a few days after her son, Eddie, was diagnosed with PKU. Like many parents of sick newborns, Mielke was frightened. "It's a hard thing to accept when you find out your son has a metabolic disorder," she says. "But Dr. Fisch was always there for me. Doctors are doctors, as far as I'm concerned, but I've never met a doctor like Dr. Fisch. He just gives and gives and gives."

But Fisch was not always so open with others. When he returned to Budapest after his incarceration, he says, "I was just like a burned-out building. No feelings. No nothing. Everything looked haunted." For years he would not talk about his experiences. "This is like any other disease. You want to deny. You don't want to talk about it. You want to forget it. You can't, of course, because inside of you, it grows. But initially, why want to share when you go through hell? You don't want to share."

> "The message I would like to send is: Remain human—even in inhuman circumstances."

Now Fisch is eager to relate his experiences in the work camps and share some of his insights, as he does through the Weisman exhibition, "Light from the Yellow Star: A Lesson of Love from the Holocaust."

"It is not enough to tell 'this is what happened.' We must ask, 'What can we do with this information? How could we avoid something like that?' The message that I would like to send is: Remain human—even in inhuman circumstances. That is number one. And number two is that you have to stand up, in time, before it's too late. In other words, you cannot state, 'I'm neutral.' There is no such thing as neutral. You have to make your stand."

Years ago, Robert Fisch faced death and hatred on a scale that few of us can imagine; today he uses both art and science to teach and to heal. And as painter and pediatrician, he performs an operation that no surgeon will ever master. "Wherever he goes and whatever he does, with his art, his writings, and with the way he's lived his life," observes Patricia Mielke, "Dr. Fisch touches peoples' hearts." MM

Douglas Clement is a free-lance writer in Minneapolis.

EXAMS

(continued from page 9)

comfortable. And, if you asked me if it hurt when you were flipping my uterus around, I would say yes. Actually, it feels weird, rather than hurting. If the patient tenses up during a bimanual examination, the examiner's first reflex is to say "Relax!" But, again, this doesn't communicate specifically what you want the patient to do. "Make your belly ("abdomen," if she has a college degree) soft so I can push it and feel what's underneath it," gives the patient the feeling that she is being told what's going on and, I believe, makes her more cooperative.

The key word is "communicate." Not only does the patient have a right to know what you are doing to, and finding out about, her body, but being treated as worthy of this knowledge makes her more cooperative. I've heard of a very progressive medical school (I hope it's not apocryphal) where every male student is placed in stirrups and a strange female physician comes in, squeezes his balls, and leaves without saying a word. If you think that would make you feel hostile and insecure, you might understand why women are so ready to complain.

My suggestions should be doubly or triply adhered to if the patient is very young, or if it is her first pelvic examination.

I learned my method of speculum insertion from a man and added some refinements of my own. I add this because I don't mean to imply that only a woman can, or should, be an empathetic gynecologist. But doctors only learn how patients feel by being patients or listening to them. All patients who get pelvic examinations are women so, open your ears, men. You'll never learn from personal experience. MM

Reprinted with permission from Magee J. The pelvic examination: a view from the other end of the table. Ann Intern Med 1975;83:563-4. ©1975 American College of Physicians.

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The Monitor
News For Minnesota Physicians

Announcements

Sketch the Plan to Help Minnesota Kids Arrive Alive in 2005

The MMA is one of the coordinators of the Safe Kids Summit, the first Minnesota Childhood Injury Prevention Conference. Physicians, especially those specializing in family practice, pediatrics, and emergency medicine, are encouraged to attend this conference on Thursday, May 12, 8:30 a.m. to 4 p.m. at the Eden Prairie City Center, 8080 Mitchell Road, Eden Prairie. The registration fee is $55. For more information, or to request a registration form, call Minnesota Safe Kids, 612/291-9150 or 800/444-9150.

MMA Endorses Fund-raiser for People with Disabilities

The MMA has endorsed "Made in the Shade," a noncompetitive event for walkers, runners, and wheelers on Saturday, June 4, 8 a.m. to 11 a.m., around Lake Calhoun and Lake of the Isles in Minneapolis. The event will raise money for Partnership Resources, Inc., one of six participating organizations that serve people with developmental disabilities. Partnership Resources, Inc., creates partnerships between people with disabilities and the community through a variety of means, including employment services and educational and recreational opportunities.

Please mark your calendars and start collecting pledges for Partnership Resources, Inc. You'll receive a T-shirt and enjoy a beautiful spring morning with a great group of people. If you collect $25 or more, the $10 registration fee will be waived.

For more information, or to register as a Partnership Resources, Inc., participant, call Sandi Bruchert at 612/925-1404.

MMA Supports Funding Bills and Repeal of 2 Percent Tax

The Minnesota Medical Association is vigorously urging legislators to support three funding proposals that would provide money for health system reform.

Repeal the 2 Percent Provider Tax

S.F. 2558, a bill that would repeal the 2 percent provider tax for all providers except hospitals and surgical centers, passed out of the Senate Tax Committee April 11 and, as *The Monitor* goes to press, is waiting to be heard on the Senate floor. Introduced by Sen. Linda Berglin, DFL-Minneapolis, this bill would replace the provider tax with an income tax increase that would raise enough money to fund the existing MinnesotaCare program and would allow a scaled-back expansion to take place on October 1, 1994. On that date, individuals and families without children who earn up to 125 percent of the federal poverty level would be able to enroll in the MinnesotaCare program. The funding bill would impose a progressive increase in state income taxes with the heaviest burden falling on the highest income levels. For example, state taxes on the portion of a married couple's income that exceeds $75,000 would go from 8.5 percent to 9.7 percent.

In the Senate Tax Committee hearing, Berglin offered an amendment that would keep the provider tax on hospitals and surgical centers. Reportedly, in 1992, when the "Gang of Seven" drafted the original MinnesotaCare legislation, all the legislators on the bipartisan committee except former Rep. Paul Ogren, DFL-Aitken, had intended the tax to be imposed solely on hospitals, which they considered better equipped to handle the additional administrative responsibility. Ogren had insisted on taxing physicians as well.

Berglin's amendment was accepted. The funding bill was adopted and is on the floor of the Senate waiting for a hearing.

The House companion bill, H.F. 3220-Greenfield, would repeal the tax for all providers, including hospitals and surgical centers, and would raise the highest level tax increase to 10.2 percent rather than 9.7 percent. The House bill passed the House Taxes Committee and goes to the House Ways and Means Committee.

Increase Cigarette Tax

As an alternative to Berglin's repeal bill, Sen. Duane Benson, IR-Lanesboro, offered an amendment that would repeal the provider tax and replace it with a 20-cent increase in the cigarette tax in 1995, and an additional 23-cent increase in 1996. His amendment failed in committee on a 9-9 tie vote. Benson plans to offer his amendment on the floor of the Senate. He believes his bill has a better chance of being signed by the governor than the Berglin bill.

The Senate Tax Committee did not take up the universal coverage proposal promoted by the Minnesota Hospital Association that would have speeded up the health care reform timetable, left the provider tax

Funding continued on page 36

Funding *continued from page 35*

in place, and added an increase in the income tax. The funding bill, S.F. 2494-Janezich, that would replace the provider tax with an income tax surtax, has also failed to advance.

Transfer Funds

Sen. Douglas Johnson, chair of the Senate Tax Committee, introduced S.F. 2874, a bill that would transfer $75 million from the state reserves to the health care access fund. The proposed transfer of funds would put the state back on track, following the timetable set by the 1992 MinnesotaCare legislation. The 1992 MinnesotaCare Act set a target date of July 1, 1994, for enrolling families without children who earned up to 275 percent of the poverty level, but only if there was enough money in the program. With state funds rapidly running low, however, Berglin introduced an amendment to this year's MinnesotaCare bill that would push back the enrollment date to October 1, 1994, and change the eligibility level to 125 percent, so fewer people could enroll. Currently, her amendment is attached to both the House and Senate 1994 MinnesotaCare bills.

The Senate Tax Committee adopted S.F. 2874 and referred it to the Senate Finance Committee. The House companion bill, H.F. 2951-Rukavina, passed the House Taxes Committee and was referred to the House Ways and Means Committee.

As these funding proposals show, the MMA has convinced many legislators that the provider tax is an inappropriate funding source and an administrative nightmare. This shift in thinking is a significant victory for the MMA, but the rejoicing may be short-lived. Gov. Arne Carlson still threatens to veto any increase in taxes. The MMA is arguing that S.F. 2558/H.F. 3220 and S.F. 2494/H.F. 1951 do not raise taxes, but shift the funding source from a provider tax to a stable broad-based source of revenue. The MMA has issued a "legislative alert" urging support for these bills. • • • • •

MinnesotaCare Bill Passes Senate

The MinnesotaCare bill, S.F. 2192, passed the Senate April 18 on a vote of 41-23, and as *The Monitor* goes to press, its companion bill, H.F. 2525, is expected to go to the House floor within the next few days. A conference committee will reconcile differences between the House and Senate versions.

State May Sue Federal Government Over Unfair Medicare Reimbursement

The Senate Finance Committee accepted an amendment to the MinnesotaCare bill, offered by Sen. William Luther, DFL-Brooklyn Park, and initiated by Attorney General Hubert Humphrey III, that would set aside $200,000 to pay for attorneys and researchers to investigate grounds for a possible lawsuit against the federal government over the unfair level of Medicare reimbursement for Minnesota physicians. The MinnesotaCare bill's author, Sen. Linda Berglin, DFL-Minneapolis, supported the amendment with the understanding that Luther would find a way to pay for it out of the general fund rather than the health care access fund before the bill came to a vote, or else the amendment would be removed.

Republicans on the committee argued that the money should come out of the attorney general's budget and objected to having the amendment introduced at the last minute. "We're in the phone book," Sen. Duane Benson, IR-Lanesboro, said. "We've been here all year."

Commissioner of Health Mary Jo O'Brien spoke against the amendment, telling committee members that the state was involved in delicate negotiations with the Clinton administration over requests for a number of waivers, and an impending lawsuit could have an adverse effect. She assured the committee that the state was working on the issue of low Medicare reimbursement.

Luther said it was time to "get some muscle behind our talking." Sen. Don Samuelson, DFL-Brainerd, agreed, pointing out that we've been negotiating through our Congressional delegation for years and haven't made much progress. Berglin said Congress was likely "to take this inequity more seriously if there was a lawsuit" and suggested we "turn up the volume on this issue."

Republicans tried unsuccessfully to insert a provision that would call for the attorney general and the commissioner to share funds for researching the issue. As a compromise, a line was inserted into the amendment that asks the attorney general to work cooperatively with the commissioner of health in an effort to improve Minnesota's Medicare reimbursement, but the funds go to the attorney general.

Later, on the floor of the Senate, Benson offered an amendment that would change the funding source from the health care access fund to the general fund. His amendment was adopted.

The Minnesota Medical Association strongly supports aggressive efforts to correct the geographic disparities in Medicare reimbursment. This important amendment is on the Senate bill, not the House bill, and the MMA will urge legislators to include it in the conference committee bill.

MMA Supports Senate Ban on Exclusive Contracts

The MMA strongly supports the ban on exclusive contracts in the Senate version of the MinnesotaCare bill. This provision would prohibit contracts that require providers not to contract with any other integrated service network or third-party payer unless the provider is an employee.

The House bill also includes a provision on exclusive contracts, but

Senate continued on page 37

Senate continued from page 36

it would take effect too late to have much impact. The House language would prohibit exclusive contracts only when an organization changes the status of its licensure. This would allow health plans and hospital systems to continue signing up physicians and clinics until they become licensed as an integrated service network (ISN). By that time, physicians and clinics who have been pressured into signing exclusive contracts may have already given up a significant portion of their business and would be almost entirely dependent upon the business generated under the exclusive arrangements. If they chose to leave the system, they would have to start over and develop a new patient base.

Currently, most physicians provide services to patients belonging to many different plans. This allows a range of choices for both physicians and patients. But if physicians feel pressured to sign exclusive contracts, this will no longer be the case. The MMA is urging legislators to adopt the Senate language.

Anti-Merger Proposal Amended to Senate Bill

The Attorney General's proposal to prohibit health carrier mergers that would result in one company serving more than 10 percent of the statewide health care market was amended to the Senate bill. This provision would affect health plans, but not hospitals. Although it would have little or no effect on smaller mergers, this bill would prevent the three major plans, Allina, HealthSpan, and Blue Cross and Blue Shield, from merging, or another plan from replacing one of them. This provision is not part of the House bill.

Net Worth Corridor Proposal Is Amended to Senate Bill

An amendment was added to the Senate bill that was designed to level the playing field regarding insurance reserves. The reserve corridor for an ISN will be significantly narrower than the reserve corridor for a health plan corporation such as Blue Cross and Blue Shield of Minnesota. If BCBSM became an ISN, it could ratchet down its current level of reserves. The question is—what happens to the excess money? Some legislators fear this windfall would give an enormous advantage to BCBSM, which might spend down by low balling its premiums and attracting a wealth of new customers, or by buying new equipment or clinics. The Senate amendment would require existing health plans to present a plan to the state describing how they intend to use their excess reserves before they could be licensed as a new HMO, ISN, or community integrated service network (CISN). The House bill does not have this provision but would limit CISN net worth to no more than two and one-half times the minimum net worth requirement.

House and Senate Bills Differ Regarding Allied Provider Network

The amendments regarding the use of allied health care providers have undergone many changes. The House bill would require CISNs to establish an expanded network of allied providers, but it would place no requirements on other health plan companies. The Senate bill would make the expanded network voluntary for CISNs, but mandatory for other health plan companies. The MMA supports the Senate language but continues to press for a requirement that CISNs offer a "point-of-service" option allowing enrollees to see any provider. The MMA-proposed language would include physicians as well as allied health care providers.

Senate Bill Calls for Study of Anesthesia Practices

An amendment was adopted on the Senate floor that calls on the commissioner of health to study and report to the Legislature on anesthesia services provided in hospitals by nurse anesthetists and anesthesiologists. The study would compare contracts between hospitals, nurse anesthetists and anesthesiologists in terms of quality, cost, and possible anticompetitive effects. The report would also include the commissioner's recommendations on the most appropriate and cost-effective way to provide anesthesia services.

House Bill Includes Rural Initiatives

The House bill would provide start-up loans for CISNs, a summer intern program for high school juniors and seniors, rural hospital grants for emergency room coverage, plans for the University of Minnesota-Duluth to become a four-year medical school, and a study of the need for a physical therapy degree program. The House bill also would establish demonstration projects at four rural sites to encourage physicians to serve as locum tenens. The Senate bill does not include these provisions.

Bills Differ in Other Ways

The Senate bill would not allow preferred provider organizations to continue beyond December 1997; the House bill would allow them to continue but not to negotiate fee schedules below the RAPO rate. The Senate bill requires an ISN to be nonprofit; the House bill does not. The House bill would not allow a health care provider or company to pay any employee more than 25 times the amount paid the lowest paid employee; the Senate bill has no such provision. The House bill would exempt revenues for services to non-Minnesota residents from RAPO and from the ban on Medicare balance billing; the Senate bill has no such provision. The House bill includes a proposal to create cooperatives of health care buyers and sellers; the Senate bill does not. The House bill calls for a pilot study that would collect data from providers about the opportunities and barriers to the provision of quality, cost-effective care; the Senate bill does not. • • • • •

LEGAL ISSUES

Pipe fitters' Trust Loses Challenge to 2 Percent Tax

The U.S. District Court has found in favor of the state in the lawsuit filed by the Twin City Pipe Trade's Welfare Trust and the employee benefit plans of 11 other self-insured unions. The lawsuit challenged the legality of the 2 percent MinnesotaCare tax, contending that it conflicts with two federal laws: the Employee Retirement Income Security Act (ERISA) and the Labor Management Relations Act (LMRA).

The trust argued that the MinnesotaCare provision that allows providers to pass the 2 percent tax on health care services through to third-party payers, including the self-insured plans, violates the ERISA requirement that assets in an employee benefit trust must be used *exclusively* for the benefit of plan participants and an LMRA requirement that the assets contributed to a joint labor management trust must be used *exclusively* for the benefit of employees, their families, and dependents. The court disagreed, saying that the same interpretation could be used to challenge every state law that increased costs to a self-insured plan, such as a sales tax or minimum wage law. "In short, if ERISA is held to invalidate every state action that may increase the cost of operating employee benefit plans, those plans will be permitted a charmed existence that was never contemplated by Congress."

The trust also argued that MinnesotaCare data collection and reporting provisions are pre-empted by an ERISA provision exempting self-insured employee benefit and pension plans from state regulation. The court ruled that since MinnesotaCare only "encourages" self-insured employers to comply with the reporting requirements, the trust does not have standing to challenge it. This ruling suggests that the data collection requirements will not apply to self-insured plans.

Finally, the trust contended that the MinnesotaCare health carrier spending cap is pre-empted by ERISA. The court ruled that because the trust does not fall within the statutory definition of a "health carrier," it does not have standing to challenge the spending cap. This ruling suggests that the carrier spending cap will not apply to self-insured plans.

The Pipe Trade Trust is expected to appeal the District Court's decision to the Eighth Court of Appeals.

This ruling may mean a loss of momentum for legislation to repeal the 2 percent tax, but on the other hand, it makes it clear that providers can pass the tax through to ERISA plans and they can itemize it.

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Provider Tax Jeopardizes Federal Matching Funds

It is not clear whether Minnesota will succeed in getting the federal waivers needed for the 2 percent tax from another federal law—the provider tax law. Even though the 2 percent tax revenues are used to fund MinnesotaCare not Medicaid programs and do not draw additional federal Medicaid money, the provider tax law applies, and violation could mean the loss of federal matching funds for Medical Assistance, Minnesota's Medicaid program.

There are two major problems with Minnesota's 2 percent tax.

- Federal law allows states to levy provider taxes only on certain defined classes of providers, and the 2 percent tax falls on some health care providers who are not on the federal list.
- The law requires that any provider tax be broad-based, and the MinnesotaCare tax is not imposed on services to MinnesotaCare and Medical Assistance patients.

The governor's office, the Department of Health, and the Department of Human Services appear confident that they will succeed in getting the necessary waivers and exemptions from the Clinton administration. They are urging legislators not to make any changes in MinnesotaCare funding this year and to wait for federal action. Some DFL legislators are skeptical.

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Attorneys General Oppose Federal Pre-emption

The National Association of Attorneys General (NAAG) opposes the pre-emption of state antitrust law by any federal health care reform legislation. At the March 21 spring meeting, the NAAG adopted a resolution to oppose federal pre-emption, especially with respect to health care providers. The attorneys argue the health care industry varies from state to state, and the "erosion of state sovereignty and federalism constitutes a threat to our constitutional form of government." The NAAG takes the position that the attorneys general, "as chief law enforcement officers, should continue to have primary responsibility for preventing anticompetitive behavior within each state."

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Kentucky Court Upholds Provider Tax

The Kentucky Medical Association lost its legal challenge to Kentucky's 2 percent provider tax, which is used to finance the state Medicaid program. The association had argued the tax was unconstitutional because it calls for one group to pay for a program that benefits the whole state. The Kentucky Supreme Court disagreed, saying the same argument would make the progressive income tax and sales tax exemptions unconstitutional as well.

LEGISLATIVE NEWS

MMA Opposes Informed Consent Provision

A controversial House amendment to the welfare reform bill, the so-called "informed consent" provision, is in limbo as *The Monitor* goes to press. The bill passed the Senate by one vote April 14, then following a decision to reconsider, was tabled. Legislators are working to develop compromise language that would be acceptable to the governor. The MMA opposes the provision.

The informed consent amendment, offered on the House floor by Rep. Stephanie Klinzing, DFL-Elk River, specifies the information physicians must give a patient in order to obtain informed consent for an abortion. The treating or referring physician would be required to tell patients about fetal development, abortion alternatives, health risks, and the name of the physician performing the abortion at least 24 hours before the procedure. The House amendment was accepted, and the bill passed the House on a 82-50 vote.

On the Senate floor, heated debate broke out between anti-abortion and pro-choice legislators over whether to accept the House amendment or send the bill to conference committee. A motion to accept the House language squeaked by the Senate on a 34-33 vote, but when the governor indicated he might veto the bill, a motion to reconsider passed and the bill was tabled. If the Senate takes the bill off the table it must accept the House amendment or send the bill to conference committee. A more likely scenario is that a revised version of the proposal would be offered as an amendment to another bill.

The MMA opposes the informed consent proposal as a dangerous precedent that would intrude into the physician-patient relationship and expand malpractice exposure. The provision is unnecessary. Case law already requires physicians to obtain informed consent. MMA lobbyists urged legislators to send the bill to conference committee so the informed consent provision could be modified or deleted. A letter to key senators and the governor from C. Randall Nelms, M.D., MMA president, warns that the provision would increase the number of lawsuits and, therefore, raise health care costs at a time when the state is struggling to control these costs. As *The Monitor* goes to press, Sen. Sheila Kiscaden, IR-Rochester, is drafting compromise language that she hopes to offer as an amendment to other legislation. The MMA is working with her and other legislators in an effort to improve the new language and make it less onerous to physicians.

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BMP Diversion Program Bill Advances

The diversion program bill, S.F. 1849-Piper/H.F. 2120-Kelley, drafted by the Board of Medical Practice (BMP), with amendments to protect physicians' due process rights, passed the House and is waiting to be heard in the Senate Finance Committee as *The Monitor* goes to press. The BMP bill would allow two or more health licensing boards to create a joint program to evaluate, treat, and monitor licensed health care providers who suffer from mental, physical, or psychological problems. This program would operate outside the boards' disciplinary processes.

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Licensing Board Bill Is Dead

An MMA-opposed bill, H.F. 916, introduced by Rep. Steve Kelley, DFL-Hopkins, failed to meet the committee deadlines and appears dead for this session. The MMA opposed this bill out of concern that it could lead to a "super board," a unified licensing entity that would regulate all health-related professions. This concept is inconsistent with the physician tradition of self-regulation. The proposal may be back next year. During a hearing in the House Health and Human Services Committee, legislators urged the health associations to work with the licensing boards to resolve their differences on this issue.

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Seat Belt Law Defeated

The House defeated a bill, H.F. 2005-Greenfield, that would have allowed police officers to stop motorists for failure to wear a seat belt. Under current law, drivers can be ticketed for not wearing seat belts only if they are stopped for another offense. The MMA supported this public safety measure, which was recommended by the Minnesota Health Care Commission's consumer incentives report. The report focused on ways to prevent illness and injury and thus reduce health care costs.

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Minnesota May Certify Acupuncturists

The bill, H.F. 1598-Leppik/S.F. 1369-Sams, which would certify acupuncturists, has been amended to the Omnibus Health and Human Services Funding bill and is likely to pass. The provision would require anyone practicing acupuncture in Minnesota to be certified by September 1, 1994. Medical doctors, osteopaths, and chiropractors who perform acupuncture would be exempt from this requirement. Acupuncturists have unsuccessfully sought state certification for several years.

National Safe Kids Week is May 8-15

LEGISLATIVE NEWS

Mandatory Drug Purchasing Program Defeated

An MMA-opposed bill, S.F. 2381-Finn, that would have required the state to bid for all prescription drugs in Minnesota failed to meet committee deadlines and is dead for this session.

In a letter to members of the Senate Health Care Committee, the MMA expressed skepticism about the state's ability to buy drugs for the entire state at a lower price than many patients are already paying. In addition, the letter expressed concern over a provision in the bill requiring recommendations for a statewide formulary. The development of a state formulary could make it hard for patients to obtain appropriate prescription drugs.

As an alternative, the House Human Services Finance Division adopted an amendment to the MinnesotaCare bill that asks the commissioner of health to develop recommendations for the creation of a voluntary "pooled prescription drug purchasing program." The amendment, offered by the chair of the committee, Rep. Lee Greenfield, DFL-Minneapolis, is intended to help Minnesotans who don't have insurance coverage for drugs. The proposed program would be administered by a private vendor supervised by the state and would not disrupt or affect existing arrangements for the management of prescription drug benefits. The amendment is not on the Senate bill.

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Anti-Smoking Bills Advance

An amendment to the Clean Indoor Air Act, S.F. 0372-Merriam/H.F. 423-Huntley, that bans smoking in the common areas of apartment buildings passed both the House and Senate and is on its way to the governor. The MMA strongly supported this bill to protect people from the dangers of secondhand smoke.

The MMA also testified in favor of a bill that would require the commissioner of health to educate the public about the danger of exposing children to secondhand smoke. This proposal has been incorporated into the Omnibus Health, Jobs and Training bill, H.F. 3207, and is in the House Ways and Means Committee.

Claims Processing Changes for State Programs

• • • • • The long-awaited Minnesota Medicaid Management Information System (MMIS II) for Medical Assistance, General Assistance Medical Care, and MinnesotaCare claims will be in full operation on May 31, 1994.

New Provider Numbers

When submitting new claim forms in the new system, providers must use a new nine-digit provider number. If you don't have your new provider number, call the MMIS II Provider Help Desk at 800/657-3739 or 612/296-7675 immediately to obtain a re-enrollment packet. May 6, 1994, is the last date for old claims and prior authorization forms to be accepted.

Free Electronic Claims Submission Software

Early in May the Information Transfer System (ITS) software will be mailed to providers who have requested it. If you wish to consider ITS as a claims submission option, call the Electronic Data Interchange Unit at 800/657-3651 or 612/296-4931.

Pharmacy Point of Sale

Point of sale transactions for pharmacy providers will be available by May 31, 1994. Value-added networks (VANS) and service bureaus will contact pharmacies regarding implementation procedures.

Eligibility Verification System

The Eligibility Verification System (EVS) is an automated voice response system that providers should use to check recipient eligibility. Beginning May 31, call EVS at 800/657-3613 or 612/282-5354.

Provider Workshops

Provider workshops for billing staff are being offered throughout Minnesota through May 13, 1994. If billing staff did not attend the workshops offered in the fall of 1993, please call the MMIS II Provider Help Desk at 800/657-3739 or 612/296-7675 to register for the workshop nearest you.

Announcements

Plan to Attend the MMA/MSBA Dinner

The Minnesota Medical Association and the Minnesota State Bar Association will jointly sponsor their fourth annual dinner and discussion May 9, 1994, 6 p.m. to 9:30 p.m. at the Sheraton Inn Midway in St. Paul. This year's discussion on the "Politics of State and Federal Health System Reform" will address the following topics:

- state health reform initiatives passed during the 1994 legislative session;
- federal health system reform proposals;
- the role of politics in state and federal health reform;
- the impact of health reform on the practice of medicine and on laws that affect physicians.

Guest speakers include Sen. Sheila Kiscaden, IR-Rochester, and Danny Miller, J.D., Washington, D.C., office of Faegre & Benson.

The Minnesota Medical Association is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The MMA designates this continuing medical education activity for two credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

The registration fee is $29. To request a registration form, call the MMA, 612/378-1875 or 800/999-1875.

MMA Urges High Schools to Eliminate Early Starting Hours

Sleep deprivation can have serious consequences for adolescents, warned Speaker of the MMA House of Delegates Barbara P. Yawn, M.D., in a letter to 400 Minnesota school superintendents. The MMA is urging schools to change school starting hours to recognize teenagers' biological need to sleep longer and later than younger children. Her action came in response to a resolution adopted by the 1993 House of Delegates calling on the MMA to urge school districts to eliminate early starting hours for teenagers and to publicize information about adolescents' sleep needs.

The MMA House took action on this issue because scientific studies show that many adolescents need more than nine and one-half hours of sleep—more sleep than children or adults—just when demands on their time are increasing. Many young people who are juggling school, jobs, sports, homework, and socializing, cut back on their sleep—sometimes with disastrous results. Lack of sleep can interfere with learning and cause accidents.

It's not just social pressure, sports, and jobs that keep teenagers up late. The body's natural circadian rhythm, its sleep/wake cycle, changes during puberty so most teenagers stay alert later at night and are sleepier in the morning. The shift in their biological time clock makes it hard for teenagers to doze off early enough to get all the sleep they need in time for an early class. Despite these scientific findings, many Minnesota schools start classes earlier for older adolescents than for younger children.

Lack of sleep can be dangerous. Young drivers who suffer from sleep deprivation have trouble concentrating and may even fall asleep behind the wheel. Motor vehicle accidents were the second largest single cause of death in persons aged 15 to 24 years in the United States in 1989. The U.S. Department of Transportation estimates that 200,000 automobile accidents each year may be sleep-related, and 20 percent of all drivers have fallen asleep behind the wheel.

The danger is worse if fatigue is combined with alcohol, tobacco, or other drugs. "One or two beers in a sleepy adolescent can be seriously impairing," said Mark W. Mahowald, M.D., director of the Minnesota Regional Sleep Disorders Center. "Sleep deprivation and alcohol are a dangerous mix."

Sleep deprivation also interferes with learning. "Sleep deprivation among teenagers severely undermines the educational mission of our schools," said Maurice W. Dysken, M.D., immediate past president of the Minnesota Psychiatric Society. "Sleepiness causes impairment of perception, reasoning, performance, and judgment. Sleep loss affects performance on virtually all cognitive and sustained attention tasks."

Sleep loss is cumulative. After a week battling their biological time-clocks, exhausted teenagers try to catch up on their sleep on the weekends, but often their parents shake them out of bed. "Napping and sleeping late doesn't mean an adolescent is lazy, depressed, or slothful," said Mahowald. "Sleep is a biological imperative. The body needs sleep the way it needs food or drink."

Yawn's letter and an MMA news release aroused an overwhelming media response. Clearly, people want to hear from physicians about medical facts that have implications for public policy. Teachers and parents, as well as reporters and school superintendents, called the MMA to comment. While some complained about scheduling difficulties and the availability of buses, many people thanked the association for leadership on this issue.

Limited Hearing Will Review HealthSpan Merger

A limited hearing will be held to review the HealthSpan merger application Monday, May 23, from 9 a.m. to 4 p.m. in the Chesley Room of the Minnesota Department of Health. HealthSpan is seeking the commissioner of health's approval of its application to protect the merger of Health One and LifeSpan from federal and state antitrust liability.

The HealthSpan merger will result in a notably larger hospital network with estimated revenues of nearly $1 billion from health-related services. The new HealthSpan hospitals will include metropolitan-based Abbott Northwestern, United, Mercy, and Unity and will account for approximately 20 percent of revenues for all Minnesota hospitals.

The limited hearing will focus on whether the cost savings achieved by the merger will be passed on to consumers of health care services. The commissioner will make the final decision on whether to approve the application. HealthSpan has 20 days from the date of the order to submit written evidence in response. The public has 40 days from the date of the order to provide written comments on this evidence. Public comments should be sent to the commissioner of health.

Revised Infectious Disease Manual Is Available

The manual, "Infectious Diseases in Child Care Settings: Information for Directors, Caregivers, and Parents or Guardians," last published in 1987, has been revised and is now available. The third edition includes general information, current recommendations, and reporting requirements on 38 diseases of public health concern in child care settings, 11 more than the previous edition.

Manuals are being distributed by local agencies in the metropolitan area, and by the Hennepin County Community Health Department outside the metropolitan area. The cost per manual is $15, which includes shipping, handling, and Minnesota state tax. In the metropolitan area, contact your local city or county health department for more information and an order form. In Hennepin County and Greater Minnesota, call the Hennepin County Community Health Department at 612/348-2741.

Hamline Receives Grant to Improve Rural Practice

Hamline University has received a $20,400 grant from the Otto Bremer Foundation to improve rural family medical practice. Under the program, up to eight Hamline undergraduate pre-medical students will spend four weeks this summer with rural-based family practice physicians in Minnesota and eastern Wisconsin. "It is our hope that exposing these young people to the many attractions of rural family medical practice early in their educational careers will lead them to become family practice physicians in rural areas after medical school," said Hamline's project director Walter W. Benjamin, a medical ethicist and professor at Hamline University. "We hope to spark their interest early and hope that it will continue throughout their medical training and ultimately in their careers." Greater Minnesota is short 200 physicians, and the need is growing every month.

MMA Co-sponsors Health Care Forums

The MMA is co-sponsor of health care forums on issues of medical ethics to be presented in May. "Infinite Needs vs. Finite Resources: The Brave New World of Health Care" will be presented by the Medica Foundation on Thursday, May 12, at 5 p.m. at the Lutheran Brotherhood Auditorium in Minneapolis. This evening forum will feature former Colorado governor Richard Lamm and a discussion of difficult end-of-life decisions. For more information call 612/936-1970.

"Sinners, Saints and Health Care: Individual Responsibility for Health —Ethical, Legal and Economic Questions" will be presented by the Center for Biomedical Ethics and the University of Minnesota on Thursday, May 19, 8 a.m. to 4:30 p.m. at the Hubert H. Humphrey Center in Minneapolis. This day-long symposium will examine the assumptions and beliefs about individual responsibilities for health that underlie private health benefits and public policy. Call 612/626-7600 or 800/776-8636.

The Monitor
MAY 1994

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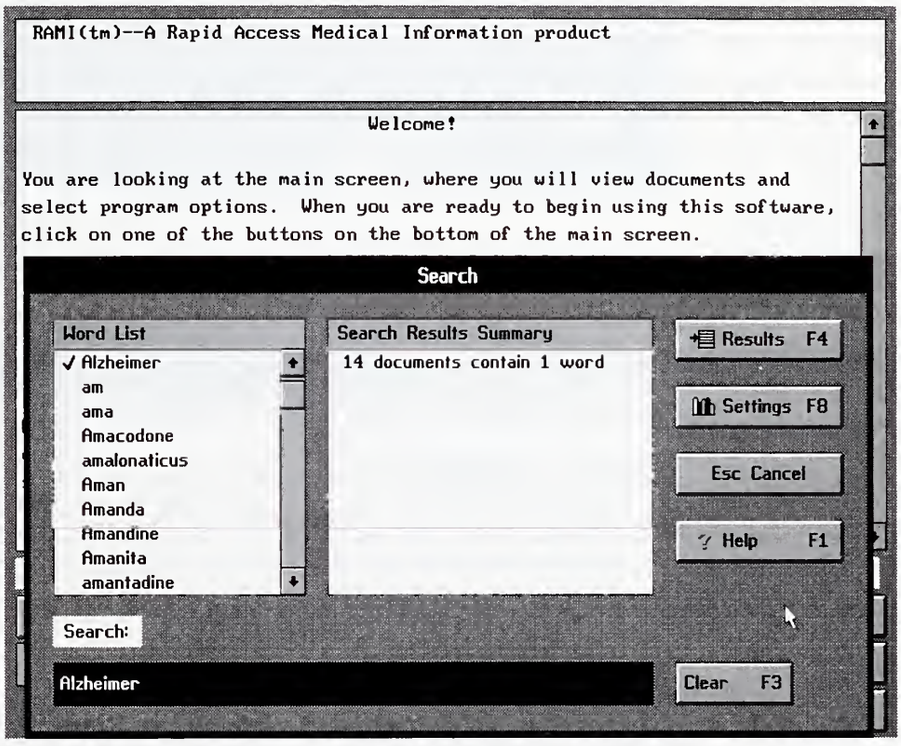
Computerized Drug Reference Eases Search for Prescribing Information

Physicians' GenRx for hard disk is a handy tool for doctors trying to practice efficient, cost-effective medicine.

Donald L. Deye, M.D.



These days, the physician caring for an elderly or fixed-income patient knows that prescriptions may go unfilled when food and utility bills are eating up limited means. Especially for the patient on calcium blockers, ace inhibitors, or other expensive medications, the cost of polypharmacy can be prohibitive.

I recently came across an interesting tool that helps address this problem. This is a PC-based program called Physicians' GenRx. It's a mouse-searchable drug reference that covers all generics and lists them in ascending order of cost. The program also includes complete FDA drug prescribing information and costs, as well as generic drug evaluations.

The "Physicians Desk Reference" (PDR) does not actually list all available medications. Many drugs long off patent are not listed because of the cost to the manufacturer. For example, in my pocket is an electronic book with a PDR cartridge that's very handy at the bedside, but it's incomplete. When a patient comes in with a bottle from another physician listing a brand name unfamiliar to me, I often won't find it in this pocket reference, usually because it's a generic drug. Unlike the PDR, GenRx for hard disk covers all FDA-approved drugs, including all generics.

The Physicians' GenRx program resides on hard disk, takes up about 13 megabytes, and pops up off the DOS shell. It can run under Windows or DOS environments. It supports a mouse, but it can be used without one. It's compatible with any DOS 3.1 or greater. It includes a quarterly update of the entire database to keep information current.

Physicians' GenRx can be quickly searched by disease type. For example, to find drugs applicable to Alzheimer's disease, I click on the "Contents" button and open the "Keyword Index" section. Here, I type in the four letters "alzh," and I'm taken to four listings under "Alzheimer's Disease." Selecting "ergoloid mesylates" brings up a short table of contents showing the key topics in the monograph. Navigating through the monograph is quick. Selecting "Contraindications" informs me that such drugs are contraindicated in patients with psychoses. After reviewing this data with my patient in mind, I jump to "Dosage and Administration," where 1 mg, three times a day, for four weeks is listed. Next I move to "How Supplied" and see that FDA-rated generic equivalents are available if I prescribe tablets and not capsules. The price difference is spelled out. The highest price for 100 tablets is $60.36 for the brand name Hydergine. The lowest-cost generic is $8.10 for an equivalent product. In this case, I choose not to write "DAW" on the prescription; patients who can afford the drug will be much more likely to take it. HMO coverage is easily determined, avoiding the need to locate different

HMO formulary books.

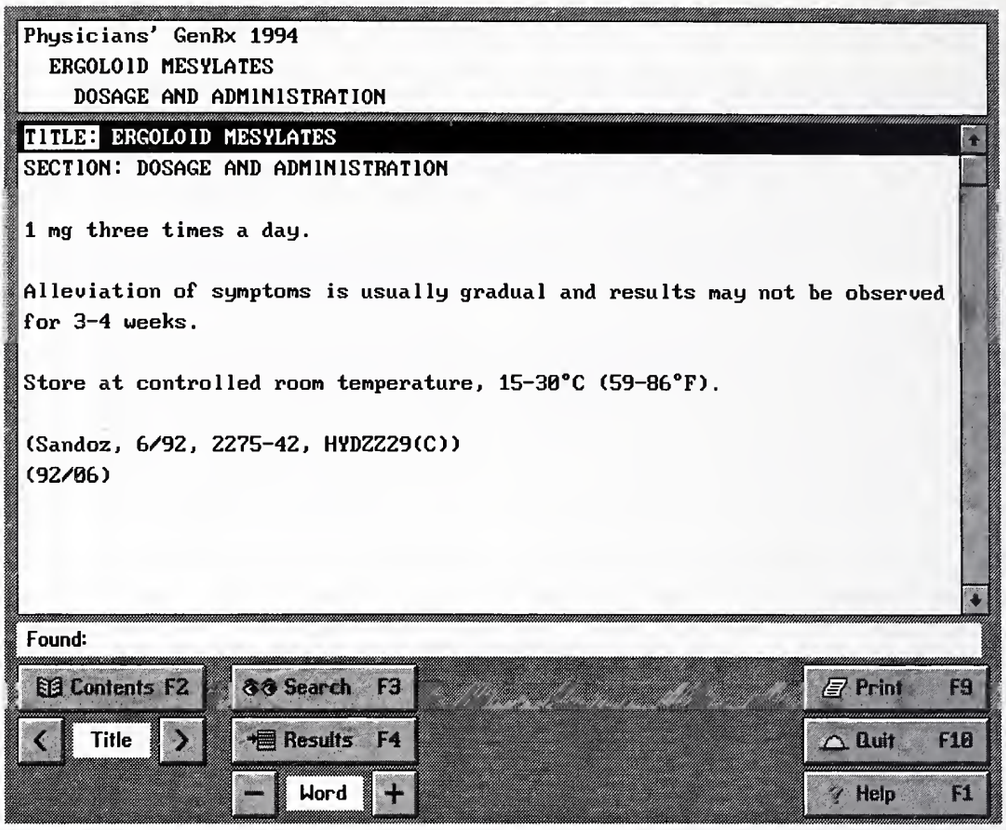
The Physicians' GenRx program is compressed data (tightly compressed to conserve disk space) from the 2,700-page "Physicians' GenRx, the Official Drug Reference." Using one index, it can be searched by category, brand name, or indication, allowing quick identification and evaluation of alternatives. Medicare reimbursement codes are provided, along with coverage by major HMO formularies.

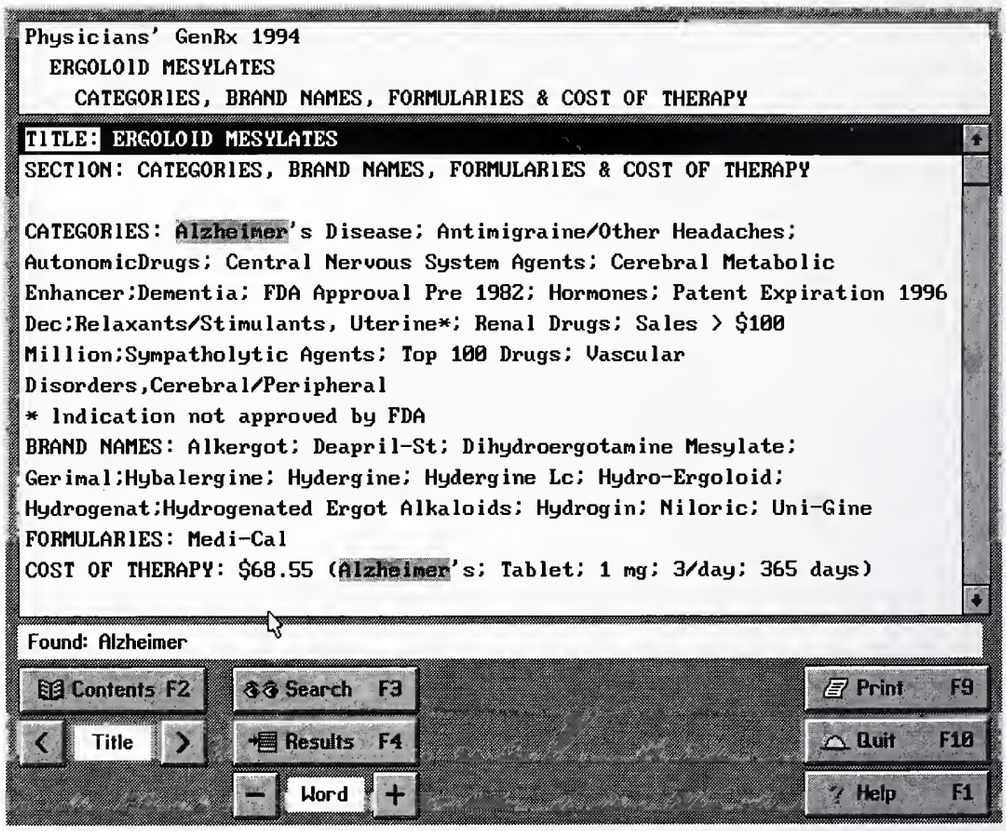
Full text searching is a powerful tool available with the program. Users can rapidly search for any word appearing in the text. I find this most useful when a patient presents with a possible medication side effect and is on multiple medications. To do this, I just select the "Search" button and key in the search terms. A window displays the number of "hits" for each term. This feature can be very helpful and dovetails with using the "Drug Interactions" section of the program.

Physicians' GenRx is a cost-effective and more inclusive alternative to purchasing separate PDR and drug interaction programs, and it is easy to learn and use. MM

Donald Deye is a general internal medicine specialist with Professional Medical Associates in Cambridge, Minnesota, and is a member of the Minnesota Medical Association Committee of Accreditation and CME.

Physicians' GenRx is available through Minnesota Medical Business Resources and is endorsed by the Minnesota Medical Association. If you would like to receive a free demo disk, simply fill out the attached postcard. You will receive the demo disk and information on how to order Physicians' GenRx.





The Art of Dying

"How We Die: Reflections on Life's Final Chapter," by Sherwin B. Nuland, M.D. (Alfred A. Knopf, 1994) is a sometimes moving, sometimes matter-of-fact, examination of death in this age of high-tech medicine.

Spencer Reece

Most people would prefer to die in their sleep—quickly and without pain—but few exits are so easy. Sherwin Nuland, M.D., a teacher of surgery and the history of medicine at Yale, now in his 70s, has written "How We Die: Reflections on Life's Final Chapter." Mortal as we are, what subject magnetizes us more? Nuland believes we have become distanced from death. Currently, 80 percent of Americans die in hospitals, and people often die alone—visit any nursing home if you need convincing. With new technology, Nuland argues, we have lost the art of dying. High tech obscures the high heavens. "How We Die" attempts to clear the stage. Laconically, matter-of-factly, Nuland reintroduces us to our deaths.

The start of Nuland's book rivets his reader. It is the 1950s. Nuland is a third-year medical student. It is late at night. An intern asks Nuland to watch over Mr. McCarty, a newly admitted coronary patient. Left alone, Nuland has no sooner sat down than the patient has a massive heart attack. With CPR still on the medical horizon, this is what Nuland does:

"With one surprisingly smooth sweep of my hand, I made a long incision starting just below the left nipple, from McCarty's breastbone around as far back as I could without moving him from his half-upright position. Another long cut through the bloodless muscle, and I was in the chest cavity. I reached over to grab the double-armed steel instrument called a self-retaining retractor, slipped it in between the ribs, and turned its ratchet just far enough to allow my hand to squeeze inside and grasp what I expect to be McCarty's silent heart."

Nuland later describes the heart as a "wet, jellylike bagful of hyperactive worms." He is unable to get the heart pumping by these manual efforts, and McCarty dies.

Over the next 200-odd pages, Nuland examines the six most common ways we die: heart disease, old age, murder, accident, AIDS, and cancer—none of them pretty. The writing is straight forward, clinical. No poetics. Each chapter begins with the facts of the disease, often followed with an account of a patient, friend, or relative of the author who has suffered the disease.

Some personal accounts stir the reader more than others. Sometimes the descriptions lack emotional depth. They read like lab studies. They feel awkwardly clinical in a book arguing strongly against this approach to death. The most moving account I know of regarding death remains Andrew Malcolm's "Someday," a book about his own mother's death at the hands of modern technology. Nuland's personal accounts sometimes read like vignettes. Every chapter begins with facts and ends with a personal story, giving the text a slightly contrived predictability. At his weakest moments, Nuland sounds like a tour guide.

Nuland is impressed by technology, but he is not zealous. He would prefer the patient die holding someone's hand rather than in a miasma of tubes, bleeps, and ventilator pumps. He encourages medical schools and teaching hospitals to place more emphasis on family practice. More heart, less plastic.

The more high-tech hope, the more removed we become from death. The larger the medical citadel, the smaller the people. The main point of Nuland's book is that an unnecessary distancing occurs between the patient, the doctor, and the patient's death. This complaint is not new, but the fact that a well-respected doctor is encouraging medicine to reexamine the way we die gives this book a particular historical significance despite its literary flaws.

Nuland writes: "Medicine's humility in the face of nature's power has been lost, and with it the moral authority of times past." Humility comes from the Latin root word humus, meaning earth. With our cavalcade of gizmos, patients become astronauts divorced from the earth. Nuland's book reminds the reader of medicine's primary purpose: to solve medical riddles without obstructing nature. MM

Spencer Reece lives and works in Northfield, Minnesota, where he is the managing editor of The Reece Report, *a national medical newsletter. He also writes medical book reviews for the Twin Cities* Star Tribune.

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TO ANNOUNCE
George Adam, M.D.
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OUR PRACTICE.

Doctor Adam received his medical degree from the University of Ottawa and served his medical internship at Queen's University in Kingston, Ontario. He practiced as a family physician in various urban and remote locations in Canada.

Doctor Adam completed his residency in neurology at the University of Manitoba and received training and developed a special interest in the diagnosis and treatment of the peripheral nervous system, Parkinson's disease and other movement disorders.

Doctor Adam will primarily practice at our Nine Ten Medical Place Office.

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Just because da Vinci missed out on AMWA membership is no reason you should!

AMERICAN MEDICAL WRITERS ASSOCIATION

Personal Choice Essential for Successful Health Care Reform

C. Randall Nelms Jr., M.D.

Leaders of the American Medical Association wrote in a February 1993 *JAMA* editorial (page 1164): "We stand at a watershed. The opportunity for physicians to do what is best for our patients in the public arena has never been better. Within our grasp is the chance to open the door to appropriate care for every child and adult, to see that every health dollar is invested in care that is right for every patient; to end outrageous administrative costs and wasteful paperwork; and to guarantee all patients the freedom to choose their own physician."

Choice is a right that Americans do not want to relinquish, and they should not be required to do so. In 1988, 89 percent of the employees in company plans could choose fee-for-service. By 1992, that number had shrunk to 65 percent. If the market continues unchecked, choice will eventually be limited to staff doctors at health maintenance organizations or integrated service networks.

Currently, the Clinton plan would offer a choice of health plans through a health alliance. At least one fee-for-service plan would be included in the alliance, giving individuals access to almost any doctor with an FFS practice. Alliances could also offer HMOs with a "point-of-service" option.

Point-of-service HMO plans are proliferating. For example, to stay competitive, Kaiser Permanente health plans are offering this option. The problem is that point-of-service plans can be expensive, and some say only the well-to-do will be able to afford them.

Many employers don't offer these doctor-choice plans, and many managed-care bills currently debated don't require them. For true competition to exist, individuals—not employers—must have the right to choose health plans, providers, and price. In addition, individuals must be able to compare the quality of various health plans and providers, and a standardized method for measuring quality must be utilized throughout the system.

"For true competition to exist, individuals—not employers—must have the right to choose health plans, providers, and price."

The United States already has the most competitive medical system in the world. It features multiple, competing insurance plans, advertising by physicians, and hospital marketing. But this style of competition is what makes American medicine so expensive. Competition works wonders in a true free market, but it is counterproductive in a medical system where consumers do not pay directly for their care.

Competition in the new system must manifest itself with accountability in personal choices. Individuals should be ensured that they have recourse if they are dissatisfied with the price or quality of services.

Not only is choice of physician important, but also choice in treatment decisions. Physicians working with patients must be able to determine the most appropriate, cost-effective care. Such decisions should not be left to some large system far removed from the individual patient.

Physicians want the opportunity to provide more choice by forming their own networks. Individual choice is assured if patients can select physicians inside or outside the network. Choice is further assured through outcomes reporting and through the ability to change delivery networks annually.

If personal choice drives the system, then the parameters and incentives are established for providers. Health plan marketing will change. First-generation managed care and second-generation managed competition will give way to third-generation care managers with managed collaboration. Care management will replace the gatekeeper. Integrated service networks will be established to promote quality, cooperation, communication, and economic efficiency. Most important, they will place the patient first with the goal of improving the health status of the individual, as well as the community.

We must have the courage to change. Change can be threatening and disruptive if the reasons are not understood. Health system reform carries with it uncertainties and doubts. It also gives us the opportunity to provide universal coverage and access while improving the health status of our communities by providing high-quality health care. By maintaining personal choice and making the individual more financially responsible for health care, we can create an affordable system. MM

Minnesota Medicine is the official journal of the Minnesota Medical Association, and its purpose is to provide Minnesota physicians with timely information regarding all aspects of medicine so they can more capably serve their patients and more readily achieve their professional goals. Therefore, the editors are pleased to consider for publication clinical and health papers (clinical studies, reviews, case reports) and essays, letters, poems, and opinion pieces related to medical practice in Minnesota.

Manuscripts

Submit clinical articles, essays, letters, book reviews, and other manuscripts at any time to: Meredith McNab, Managing Editor, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. Manuscripts are reviewed by the editors and peer reviewed by the Advisory Committee, the Review Board, and other experts in particular specialties.

Please submit two copies and keep one for your files. You may submit a Macintosh or IBM-compatible ASCII (text) floppy disk with your manuscript. Disks and copies of unpublished manuscripts will be returned to the authors. Only submit unpublished articles that have not been submitted elsewhere.

A cover letter should identify the author with whom we correspond (include address and phone number). Double-space all text on one side of paper only, including references, legends, etc., and number pages consecutively.

Receipt of manuscripts is acknowledged within 10 days, and authors are usually notified whether their manuscript is accepted within one to three months, but longer delays are sometimes unavoidable.

Title and Authors' Names

The first page of the manuscript should include: 1) a title—make it short, specific, and direct, 2) the full names of all authors, with their academic degrees, 3) authors' positions in hospitals or other institutions—include current position and the position held when the work reported in your manuscript was done, as well as academic appointments and other information pertinent to the paper's topic.

Abstract

The second page of the manuscript should include an abstract no longer than 150 words that highlights for the reader the essence of the authors' work. It should focus on facts rather than descriptions and should emphasize the importance and uniqueness of the findings and briefly list the approach used for gathering data and the conclusions drawn.

Author Responsibility

All authors should be involved in the drafting, revision, and intellectual content of the manuscript and be sufficiently familiar with the paper to defend its findings. Authors are responsible for all statements made in their work, *including changes made by copy editors*. Manuscripts are edited for clarity and grammar and to conform to *Minnesota Medicine* style, and authors receive an edited, word-processed copy of their paper for review before it is sent to the printer. Once it is set in galleys, only *minor* changes can be made.

All authors sign a copyright form that conveys all copyright ownership to the Minnesota Medical Association. This form is mailed to the authors after a manuscript is submitted to *Minnesota Medicine*, and must be completed and returned before the article is published. If the manuscript is not accepted for publication, the form is returned to the authors.

Style

Use *JAMA* style or consult the AMA's *Manual for Authors & Editors*. Use generic drug names, unless citing a brand name relevant to your findings; brand names in parentheses may follow generic names if desired. Do not use abbreviations in the title, and limit their use in the text. Avoid medical jargon.

Tables

Tables must have a title and be on separate pages. If they occupy more than one page, type "*title* (cont.)." If the data in the tables have been previously published, appropriate reference should be given in the text, and permission should be obtained from the original publisher before submission to *Minnesota Medicine*.

Illustrations

Submit two copies of illustrations, keeping one for your files. Figures should be professionally drawn or photographed, if possible. We prefer glossy, clear black-and-white photographs, but color is acceptable if the contrast is good. Do not send original artwork.

Each figure should have a label pasted on the back indicating the figure number, author names, and the top of the figure. Legends should be included in the text of the manuscript with numbers corresponding to the figures. Do not mount figures on cardboard, write on the back of the figures, or attach paper clips to them. If a patient in a photo is identifiable, a written release form from the subject must accompany the photo.

References

All references must be cited in the text and should be arranged in the order in which they are cited in the text—*not* alphabetically. Journals should be abbreviated as in *Index Medicus*.

Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. Mayo Clinic Proc 1986;61:859-64.
2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. Dis Colon & Rectum, to be published.
3. Chaterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.
4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. Pediatric Surgery, 4th ed. Chicago: Year Book Medical, 1986: vol 1, 522-33.

Financial Interest

List all affiliations with or financial interest in organizations that may have a direct interest in the subject matter of your manuscript. This information will be held in strict confidence until publication, and then will be printed with the article as is deemed appropriate in judging the validity of the article.

Reprints

Authors may order article reprints for a fee. Reprint request forms are sent to authors at the time of publication.

People and Places Making Medical News

People

Fairview Riverside Chief of Staff

Fairview Riverside Medical Center has appointed urologist **Harry Hoppmann** as its chief of staff for 1994 and 1995. Hoppmann, a partner with Urologic Physicians, P.A., in Minneapolis, has been on the Fairview staff since 1980. He also is president of the Minnesota Urologic Society, a board member of the Hennepin County Medical Society, and he is a member of the American Medical Association, the American Urologic Association, and the American College of Physician Executives.

Gillette Chief of Hip Service

Gillette Children's Hospital announced the appointment of orthopedic surgeon **Tom Novacheck** as chief of Hip Service. Novacheck has practiced at the hospital since July 1991 and is also clinical director of the hospital's Motion Analysis Laboratory.

HealthEast Immediate Care Clinic Medical Director

HealthEast has appointed **Charles L. Lick, M.D.**, medical director of the HealthEast Immediate Care Clinic. Previously located in Mendota Heights, the clinic moved to the HealthEast Divine Redeemer Hospital site when the hospital closed March 20. The clinic opened in the space once occupied by the hospital's department of emergency medicine, where Lick was former director.

Orthopaedic Academy Board Member

The American Academy of Orthopaedic Surgeons elected **Gene E. Swanson, M.D.**, to its board of directors at its 61st annual meeting. Swanson is a practicing orthopedic surgeon with the Orthopaedic and Fracture Clinic in Mankato, Minnesota.

Outstanding Achievements in Health Care Awards

Medical Alley, the trade organization for Minnesota's health care industry, presented eight awards for outstanding achievement at its eighth annual awards banquet in March. The awards and recipients are as follows: Outstanding Contribution in Research and Development, **Robert Vince, Ph.D.**, professor, Department of Medicinal Chemistry, University of Minnesota College of Pharmacy; Outstanding Contribution by a Third-Party Payer or Employer, **George C. Halvorson**, president and chief executive officer, HealthPartners; Outstanding Achievement in Health Care Manufacturing, **Medtronic, Inc.**; Outstanding Achievement in Health Care Delivery, **Richard J. Frey, M.D.**, chair and medical director, Minnesota Health Network; Outstanding Contribution to the Health Care Industry, **Winston R. Wallin**, special adviser to the president, University of Minnesota Health Sciences; Meritorious Service in Government, **Sen. Dave Durenberger**, United States Senate; Medical Alley Lifetime Achievement Award (posthumously), **Zinon "Chris" Possis**; Meritorious Service to Medical Alley Award, **Maria Brittle**, Angeion Corp.

Medical Alley Cost-Effectiveness Task Force

Andrew J. K. Smith, M.D., Ph.D., a neurological surgeon with Minneapolis Neurological Surgeons, Ltd., and president-elect of the Minnesota Medical Association, has been elected as chair of Medical Alley's Cost-Effectiveness Task Force. The group's 18 members will represent health care manufacturing, service delivery, purchasing groups, state government, and health services research and will create a community consensus on the measurement of cost-effective care. The task force will also seek to develop a practical methodology to demonstrate or assess cost-effectiveness in health care.

The task force will deliver a report of its findings, conclusions, and policy recommendations in a year.

Places

'U' ALG Drug Program Shut Down

The University of Minnesota Board of Regents voted unanimously to close the ALG drug program established by the Medical School in 1971. For 20 years antilymphocyte globulin, which was designed to suppress natural immunities to counteract rejections of transplanted organs, was licensed by the FDA to be sold on an experimental basis, but it never gained official approval from the FDA. The FDA halted sales of the drug in August 1992. The regents said the decision to shut down the program was largely financially motivated; the university would need to invest an estimated $9 million to $12 million and would need two to three more years to bring the drug on the market.

In other news about the university's ALG program, a former transplant patient is suing the University of Minnesota and two surgeons, John Najarian, M.D., and David Sutherland, M.D., alleging he was given the drug without proper knowledge that it was experimental and without being advised of the risks involved. Frank Young, who underwent a kidney and pancreas transplant in 1992, is suing for negligence and battery. The suit has been served on the university,

but as *Minnesota Medicine* went to press, it had yet to be filed in court.

New Pain Relief Clinic Opens for Cancer Patients

The Virginia Piper Cancer Institute of Abbott Northwestern Hospital has opened an outpatient cancer pain relief clinic. The staff will include physicians, nurses, a pharmacist, social worker, chaplain, home care nurse, and dietitian to create an interdisciplinary approach to pain management. The clinic staff, through medical history review and education, will advise patients and families and answer questions. They will discuss pain medications, pain-related symptoms, and methods to treat pain, and they will tailor individual pain management plans for each patient.

Mayo Helicopters Using New Navigation System

Mayo Clinic in Rochester is developing a system utilizing navigational satellites to guide its medical helicopters to patients in rural Minnesota. An emergency worker on the ground will use a hand-held receiver to tune in to satellites in the Global Positioning System (GPS) that have been put into orbit by the U.S. Department of Defense. First intended for military use, the satellites are now utilized by civilian pilots and others to pinpoint their location within 150 feet.

The Office of National Drug Control Policy has awarded Mayo a $3.15 million contract to develop and test the GPS system on its helicopter for later use by law enforcement officers to deter illegal drug trafficking. The Mayo system will include an electronic map display inside the helicopter that will locate the emergency scene (using the GPS-produced latitude and longitude coordinates) and then help guide the helicopter to the site.

Socioeconomics

Medica Offers Drug Discounts for Seniors

Medica has a developed a drug discount program, called SeniorRX, to save seniors money on their prescriptions. With SeniorRX, Medica will purchase prescription drugs at discount bulk prices and sell them at lower cost to their senior members through participating pharmacies. SeniorRX is expected to save seniors an average 15 percent per year on prescription drugs and will be available to Medica SeniorCare and PHP+Medicare members beginning June 1.

Methodist, Fairview Share Stereotactic Radiosurgery Equipment

Methodist Hospital in St. Louis Park and Fairview Radiation Therapy Center at Fairview Southdale Hospital in Edina together have purchased stereotactic radiosurgery technology for treating certain brain tumors and vascular abnormalities. The technology, which helps physicians plot the exact location of brain tumors, will be used with the linear accelerators at both hospitals.

Integral to the technology is a $250,000 treatment planning computer that will be housed at Methodist. The computer allows physicists and technologists to process data to determine precisely where radiation beams are to be delivered to avoid destroying healthy parts of the brain. The patient can then receive the treatment at either facility.

Methodist and Fairview will participate in cost-effective research analysis of stereotactic radiosurgery. The research will combine outcomes data of patients around the world who are treated similarly.

Methodist Hospital plans to collaborate with other hospitals in the Twin Cities to make the technology available to all patients who need it.

Mayo Experiences Operating Loss

The Mayo Clinic and Saint Marys Hospital in Rochester and Mayo's clinics in Florida and Arizona experienced an operating loss of $6.2 million on patient revenues of $1.33 billion for 1993. Mayo executives attributed the loss to lower Medicare reimbursement levels and higher patient care costs. Although patient registrations increased 3.5 percent to 392,910 last year, expenses rose by $148.9 million to $1.333 billion.

The Mayo Foundation had a better year, with $81 million in excess revenue over expenses due to investment earnings and contributions. Mayo is reportedly responding to the revenue drop by cutting clinic expenses, forming alliances with regional physicians, seeing more international patients, and increasing its managed care contracts.

Elderly Poor Satisfied with HMOs

Elderly patients on Medicare and Medicaid who participated in an experiment allowing them to use HMOs were just as happy with their care as those who use physicians on a fee-for-service basis, according to a University of Minnesota study published in the March 15 *Annals of Internal Medicine*. The study also found that the patients were just as healthy and that the cost of providing their care was considerably less.

The researchers randomly assigned 800 Medicare-covered poor people over age 65 in Hennepin County to HMO or fee-for-service doctors and followed them for a year. "We find no significant differences in outcomes or satisfaction," said Nicole Lurie, M.D., a researcher for the University of Minnesota and Hennepin County Medical Center who headed the study.

"The outcomes were compara-

ble at a year, including deaths [20 among HMO members, 24 among fee-for-service patients]," Lurie said. "We have looked at deaths three years out, and they are still comparable." She said any long-term differences probably won't show up for 10 years.

Minnesota Receives Grant for Violence Prevention Programs

Minnesota has received a $6.2 million grant from the U.S. Department of Justice to fund prevention programs for domestic abuse and hate crimes. The grant is part of a $358 million package that the department's Bureau of Justice Assistance will distribute to states for programs that attempt to combat violent and drug-related crimes. States can use the money for any program that has legislative authorization, on the condition that 5 percent go toward bolstering record-keeping at bureaus of criminal apprehension.

U.S. Rep. Bruce Vento, D-Minn., who announced the award, said Minnesota will probably use some of the money to improve intervention programs for child abuse, sexual assault, and racially or ethnically motivated violence.

Nurse Anesthetists Dismissed

Mercy Hospital in Coon Rapids and Unity in Fridley dismissed 38 nurse anesthetists in March, giving responsibility for their anesthesia services to a corporation owned by 27 independent physician anesthesiologists who had been supervising the nurse anesthetists. The hospitals say the move was necessary because Medicare and many insurers refuse to pay both the hospitals and doctors for anesthesia services. Other Twin Cities hospitals have also been considering the same move.

Midwest Anesthesia, an affiliate of Metropolitan Anesthesia Network Services, will provide the doctors and the nurse anesthetists to Mercy and Unity under a contract with a new nurse anesthetist corporation the hospitals helped set up.

John Murphy, vice president for operations at the two hospitals, said quality should not change, because the nurse anesthetists the doctors assign to the operating rooms will be chosen from those who had been practicing for years at the two hospitals.

St. Cloud hospital has also announced plans to dismiss its 20 nurse anesthetists July 1 and hire an independent group of physician anesthesiologists that now supervises its nurses.

New Minnesota HMO Starts Up

Northern Plains Health Plan, sponsored by Grand Forks Clinic and United Hospital, in April became Minnesota's 12th HMO. The plan will be based out of Grand Forks, North Dakota, and will serve the rural areas in northwestern Minnesota and northeastern North Dakota. The new HMO has been operating provisionally, providing health care to about 4,000 member employees of the clinic and hospital. It hopes to add another 2,000 members by 1995.

HMOs Reduced Premium Increases in 1993

Minnesota HMOs reduced premium increases, boosted enrollment, and made near-record profits in 1993, according to data released by the Minnesota Council of HMOs. HealthPartners, the state's largest HMO, decreased its premium increase from 9.8 percent in 1992 to 8.6 percent in 1993. Medica, the state's second largest HMO, reduced its increase from 13.6 percent to 8.1 percent and expects its premium increases to be about 4 percent for 1994.

All HMOs are required by law to hold one month of reserve operating expenses. Premiums originally funded the balance of the reserve accounts, but now interest on the balance serves as the yearly contribution, thus allowing HMOs to lower their premiums.

HealthPartners recorded $7.7 million in profits for the year—all from investments. Medica added $39.1 million to its reserve fund, a third of which came from premiums and two-thirds from earnings on reserves.

HMOs also contributed more than $25.5 million to the Minnesota Comprehensive Health Association, the fund for people who cannot obtain insurance elsewhere, and contributed $9.4 million to assist state Medicaid recipients.

Rates, Trends, Data

Americans Gaining Weight

The average weight of young American adults jumped 10 pounds in seven years, despite healthier diets, the National Institutes of Health reported in March. In 1992-93, the average weight of adults aged 25 to 30 was 171 pounds. In 1985-86, the average weight was 161 pounds for the same age group. The study was based on data on 5,115 people, equally divided among blacks and whites and men and women. The participants were from Minneapolis, Chicago, Birmingham, Alabama, and Oakland, California. Researchers did not attempt to find the cause for the weight gain, but they speculated that a decline in physical activity could be partly responsible.

University of Minnesota researcher Robert Jeffery, Ph.D., a professor and obesity expert, said the trend appears to be similar in Minnesota: Midwestern adults of all ages he surveyed gained seven pounds on average between 1980 and 1990.

Working Americans Cynical About Health Reform

Employees of mid-sized and large companies are skeptical about health system reform in general, and about the president's package in particular, according to a recent

nationwide survey of working Americans by the management consulting firm Towers Perrin. Many employees believe they will have to pay more to get the same or less coverage under reform. And most prefer to continue getting coverage through their employers.

The survey findings suggest two reasons for these views. First, employees are generally satisfied with the coverage they currently have from their employers, regardless of whether they are in managed care or traditional indemnity plans. They feel they're getting quality care, so they're not interested in switching to a different approach. And second, they appear to doubt the government's ability to manage a new and complex system.

A total of 1,000 employees nationwide took part in the survey, which was conducted in December 1993.

Minnesota C-Section Rates Lower

Members of Minnesota HMOs had a significantly lower rate of cesarean births in 1992 than the national average, according to data collected by the Minnesota Council of HMOs. The average C-section rate for Minnesota HMO members was 15.5 percent. This is well below the national average of 23.8 percent. The state average of 16.2 percent also was significantly lower than the national average.

Medical Research

Snoring Can Cause Problems that Masquerade as Heart Disease

Problems with breathing during sleep, such as common snoring, can stimulate angina, arrhythmia, or heart failure, according to a new Mayo Clinic study. Researchers at Mayo Clinic studied three people with obstructive sleep apnea that resembled coronary artery disease. Two obese women and an obese man were found to have obstructive sleep apnea and less heart disease than expected.

"Obstructive sleep apnea and coronary artery disease share common clinical risk factors," said William S. Loui, M.D., of the clinic's Department of Medical Oncology. "Those factors include a lower life expectancy in the most severe cases and a greater occurrence in people over the age of 50."

The study concluded that doctors should inquire about snoring and daytime drowsiness in patients with chest pain. This might help them identify significant breathing problems during sleep that may appear to be heart disease.

'U' Scientists Use DNA to Diagnose Lyme Disease

Scientists at the University of Minnesota have used the DNA expanding technique polymerase chain reaction to more accurately diagnose Lyme disease. The test involves extracting genetic material from the synovial fluid of a patient's knee and replicating it billions of times so researchers can determine whether it's from Lyme bacteria.

Some of the patients diagnosed using this method had taken antibiotics for three months, usually considered sufficient to wipe out the Lyme bacteria. Researchers at Mayo Clinic in Rochester, Minnesota, and Tufts University in Boston used the same test earlier this year to identify Lyme disease bacteria in tissue that had been frozen and stored years ago.

Jesse Goodman, M.D., an infectious disease specialist at the university, in collaboration with John Bradley and Russell C. Johnson, said the university's study will help doctors better target treatment in some patients. The study showed that Lyme bacteria may still be present even when bacterial culture tests are negative. Goodman said that flare-ups of Lyme disease symptoms years after diagnosis and treatment often were considered autoimmune reactions, but, in reality, are likely signs that the body is still fighting the infection.

In other news about Lyme disease, a potential vaccine is being tested in human trials. The vaccine's manufacturer, Connaught Laboratories of Swiftwater, Pennsylvania, does not expect to have the vaccine on the market before 1996. SmithKline Beecham is holding separate trials to test another version of the vaccine.

New Drug Reduces Ovarian and Breast Cancer Tumors

Researchers at the Mayo Clinic have discovered that Taxol, a new anticancer chemotherapeutic drug, reduces tumors in advanced ovarian and breast cancers. The drug, also known as Paclitaxel, may also help patients suffering from lung cancer. It is the first drug in a new class of anti-eoplastic agents, known as taxanes, and researchers believe it is one of the first significant cancer drugs to be developed in the last 10 years. Additional testing of the drug is planned.

Company Testing New Drug

The Minnesota company GalaGen of Arden Hills has begun human trials of the first drug that targets Cryptosporidium, the parasite that got into Milwaukee's water supply and made more than 400,000 people ill last year. GalaGen is first testing the drug, called Sporidin-G, on people with compromised immune systems, such as people with AIDS. At least 80 people with AIDS or who were HIV positive died of the illness as a result of the water contamination in Milwaukee.

The Food and Drug Administration has granted the drug "orphan" status (for drugs whose potential market is less than

200,000 people), meaning the company will have exclusive rights to it for seven years once it is approved for prescription use.

AIDS Update

Heterosexual Transmission Up

Heterosexual transmission accounted for the largest proportionate increase in AIDS cases reported in 1993, according to officials at the Centers for Disease Control and Prevention. In a related report, officials said the number of new AIDS cases more than doubled last year, largely because of a new and broader definition of the disease that took effect January 1, 1993.

Heterosexual transmission accounted for 9 percent of the total 103,500 new cases. Although this is a relatively small number, it is an increase from 1.9 percent in 1985. From 1985 to 1993, the proportion of cases attributed to sex among gay men decreased from 66.5 percent to 46.6 percent. The proportion of AIDS cases attributed to injecting drugs increased from 17.4 percent to 27.7 percent.

Emergency Workers Must Treat HIV-Infected People

Under a Justice Department settlement in an AIDS discrimination case, more than 2,000 emergency workers in the Philadelphia area must treat HIV-infected people. An awareness program will teach 1,400 firefighters and 900 emergency medical technicians how to prevent transmission of HIV, how to respect the patient's right to privacy while giving medical treatment, and how to be sensitive to the needs of HIV-infected people.

The settlement of the discrimination case, under the Americans with Disabilities Act, stems from a complaint filed by the AIDS Law Project on behalf of an unidentified HIV-infected man. While attending vocational school, the man collapsed in early 1993 after complaining of chest pains. When he told an emergency medical technician that he was taking AZT, the technician refused to touch him and told him to climb onto a stretcher himself. Several teachers helped the man onto the stretcher so he could be taken to a hospital. The city later agreed to pay the man $10,000 and write him an apology. MM

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A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

MAY 1994

May 6 **Knee Arthroscopy Under Local Anesthesia** HealthEast; HealthEast Midway Hospital, St. Paul, MN. CONTACT: Annette Anderson, 1700 University Avenue West, St. Paul, MN, 55104; 612/232-5190.

May 10 **Symposium on Gynecologic Oncology** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 11-13 **Current Concepts in Radiation Therapy** University of Minnesota; Mayo Memorial Auditorium, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 12 **Central Minnesota Medical Conference** St. Cloud Clinic of Internal Medicine, Ltd.; St. Cloud Holiday Inn, St. Cloud, MN. CONTACT: Kellee Zwilling, 1200 Sixth Avenue North, St. Cloud, MN 56303; 612/240-2155.

May 13 **Osteoporosis Conference** HCMC/HFA Office of Academic Affairs/U of M; The Minneapolis Hilton, Minneapolis, MN. CONTACT: Ann Samways, CME Coordinator, 612/347-2078, or Robin Hoppenrath, Manager, Office of Academic Affairs, 612/337-7128.

May 12-13 **Primary Biliary Cirrhosis: A Look to the Future** Mayo Foundation; Kahler Plaza Hotel, Rochester, MN. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME, Siebens 5, 200 First Street SW, Rochester, MN 55905; 507/284-2509 or 800/323-2688.

May 13-14 **Eating Disorders** University of Minnesota; Sheraton Inn Midway, St. Paul, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 14 **Symposium on Perinatal Family and Child Care** Fairview Riverside Medical Center CME; Fairview Riverside Medical Center, Minneapolis, MN. CONTACT: Marsha K. Mlejnek, 2450 Riverside Avenue South, Minneapolis, MN 55454; 612/672-4275.

May 18-20 **Delivering Integrated Medicine Under Managed Care: The Laboratories' Role** Mayo Medical Laboratories; Harold W. Siebens Building, Rochester, MN. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

May 19 **Sinners, Saints, & Health Care: Individual Responsibility for Health—Ethical, Legal, & Economic Questions** University of Minnesota; Cowles Auditorium, University of Minnesota, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 19-20 **Minnesota Academy of Family Physicians Spring Refresher** Minnesota Academy of Family Physicians; Hyatt Regency Hotel, Minneapolis, MN. CONTACT: Miriam Case, MAFP, Interchange Tower, 600 South Highway 169, Suite 1680, St. Louis Park, MN 55426-1200; 612/542-0130 or 800/999-8198.

May 19-21 **Disability Evaluation & Management** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

May 20 **Emergency Medicine Conference** Duluth Clinic Medical Education and Research Division; Duluth Entertainment and Convention Center, Duluth, MN. CONTACT: Rockie Odberg, 400 East Third Street, Duluth, MN 55805; 218/725-3838.

May 20-21 **Current Retina Practices for the Comprehensive Ophthalmologist** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

JUNE 1994

June 2-4 **Workshops in Clinical Hypnosis: Introductory and Advanced** University of Minnesota; Sheraton Inn Midway, St. Paul, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 2-4 **Controversies in Neurosurgery** University of Minnesota; Radisson Plaza Hotel, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 7 **Who Owes Whom What? Personal, Family, and Public Responsibility for Paying for Long-term Care** University of Minnesota School of Public Health; Earle Brown Heritage Center, Brooklyn Center, MN. CONTACT: Minnesota Chair in Long-term Care and Aging, U of M School of Public Health, 420 Delaware Street SE, Box 197, Minneapolis, MN 55455; 612/624-1185.

June 8-10 **American Society for Bariatric Surgery** University of Minnesota; Minneapolis Hilton, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 15-17 **Topics and Advances in Pediatrics** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 15-18 **Fifty-eighth Annual Surgery Course: Advances in Hepatic, Biliary, and Pancreatic Surgery** University of Minnesota; Willey Hall at University of Minnesota, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 17-18 **Mayo Ophthalmic Reviews** Mayo Clinic, Department of Ophthalmology; Mayo Medical Center, Rochester, MN. CONTACT: Darcie Skoda, Department of Ophthalmology, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; 507/284-1709.

June 20-24 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.

June 24-25 **Critical Care Conference** University of Minnesota; Mall of America Grand Hotel, Bloomington, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 24-26 **Bone and Soft Tissue Review Course** University of Minnesota; Location to be announced. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 27-July 1 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.

JULY 1994

July 7-9 **Chronic Lymphocytic Leukemia** Mayo Medical Laboratories; Silverado Country Club and Resort, Napa, CA. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

July 11-15 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapo-

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lis, MN 55416; 612/927-3393.

July 14-15 **Advanced Pediatric Life Support** Hennepin County Medical Center; Hennepin County Medical Center, Minneapolis, MN. CONTACT: Rachel Knudson, R.N., EMS Training, Hennepin County Medical Center, 701 Park Avenue South, Minneapolis, MN 55415; 612/347-3638.

July 15-16 **Synecologic Cytology** Mayo Medical Laboratories; Harold W. Siebens Building, Rochester, MN. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

July 25-29 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.

July 25-29 **•Malpractice Prevention in Mental Health •Effective Organizational Consultation: Developing the Necessary Skills • The Essentials of Brief Psychotherapy for Families, Couples, and Individuals** Psychotherapy Center at Columbia Hospital and the Department of Psychiatry at the Medical College of Wisconsin; Egg Harbor, WI. CONTACT: Carlyle H. Chan, M.D., Summer Institute Director, Psychiatry Department, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, WI 53226; 414/257-5995.

AUGUST 1994

August 1-5 **Psychotherapeutic Strategies with Borderline Patients • Treating Survivors of Incest and Abuse • Advance Topics in Neuropsychological Assessment and Treatment** Psychotherapy Center at Columbia Hospital and the Department of Psychiatry at the Medical College of Wisconsin; Egg Harbor, WI. CONTACT: Carlyle H. Chan, M.D., Summer Institute Director, Psychiatry Department, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, WI 53226; 414/257-5995.

Aug. 4-7 **Annual Scientific Conference of the Philippine-Minnesotan Medical Association** HCMC/HFA Office of Academic Affairs/U of M; The Breezy Point Resort, Breezy Point, MN. CONTACT: Ann Samways, CME Coordinator, 612/347-2078, or Robin Hoppenrath, Manager, Office of Academic Affairs, 612/337-7128.

Aug. 5-6 **Bleeding and Thrombosing Diseases** Mayo Medical Laboratories; Harold W. Siebens Building, Rochester, MN. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

August 8-12 **Psychopharmacology Consultations • AIDS/HIV Prevention, Therapy, and Mental Health Consultation Issues** Psychotherapy Center at Columbia Hospital and the Department of Psychiatry at the Medical College of Wisconsin; Egg Harbor, WI. CONTACT: Carlyle H. Chan, M.D., Summer Institute Director, Psychiatry Department, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, WI 53226; 414/257-5995.

Aug. 22-Sept. 2 **Twelfth Annual Occupational Health and Safety Institute** St. Paul-Ramsey Medical Center; University of Minnesota, Mayo Building, Minneapolis, MN. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

SEPTEMBER 1994

Sept. 9-10 **Disaster and Hazardous Materials Management Conference** HCMC/HFA Office of Academic Affairs/U of M; Location to be announced. CONTACT: Ann Samways, CME Coordinator, 612/347-2078, or Robin Hoppenrath, Manager, Office of Academic Affairs, 612/337-7128.

Sept. 12-13 **Pediatric Emergency Medicine Course** HealthSpan; United and Children's Hospital Conference Center, St. Paul, MN. CONTACT: Annette Carlson, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7910.

Sept. 12-14 **The Norwegian-American Orthopaedic Society** Mayo Foundation; Siebens Medical Education Building, Rochester, MN. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME and International Education, 200 First Street SW, Rochester, MN 55905; 507/284-2509.

Sept. 15-17 **Practical Surgical Pathology** Mayo Medical Laboratories; Harold W. Siebens Building, Rochester, MN. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Sept. 22-23 **Domestic Violence** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Sept. 22-23 **Fourth Annual 'Practical Pediatrics for the Primary Care Physician'** Children's Hospital of St. Paul; Children's Hospital, St. Paul, MN. CONTACT: Mickey Starr or Janet Salmey, 345 North Smith Avenue, St. Paul, MN 55102; 612/220-6109.

Sept. 23 **Contemporary Issues in Hemodialysis** HCMC/HFA Office of Academic Affairs/U of M; Sheraton Midway Hotel, St. Paul, MN. CONTACT: Ann Samways, CME Coordinator, 612/347-2078, or Robin Hoppenrath, Manager, Office of Academic Affairs, 612/337-7128.

Sept. 23-24 **The Lower Extremity Amputee: A Multidisciplinary Approach** Mayo Foundation; Mayo Foundation, Rochester, MN. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 23-25 **Annual Ambulance Medical Directors Retreat** HCMC/HFA Office of Academic Affairs/U of M; Arrowwood Resort, Alexandria, MN. CONTACT: Ann Samways, CME Coordinator, 612/347-2078, or Robin Hoppenrath, Manager, Office of Academic Affairs, 612/337-7128.

Sept. 30-Oct. 1 **Primary Care of Patients with Epilepsy** HealthSpan; United and Children's Hospital Conference Center, St. Paul, MN. CONTACT: Annette Carlson, 2810

57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7910.

Sept. 30-Oct.1 **Pelviscopic Surgery including Hysterectomy** HealthSpan; Abbott Northwestern Hospital, Minneapolis, MN. CONTACT: Don Young, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

OCTOBER 1994

Oct. 1 **Interventional Radiology** HealthSpan; Grand Hotel, Bloomington, MN. CONTACT: Don Young, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

Oct. 6-7 **Annual Forensic Science Seminar** HCMC/HFA Office of Academic Affairs/U of M; Pillsbury Auditorium, Hennepin County Medical Center, Minneapolis, MN. CONTACT: Gail Kraemer, 612/347-2075, ext. 2125.

Oct. 6-7 **Advanced Pediatric Life Support** Hennepin County Medical Center; Hennepin County Medical Center, Minneapolis, MN. CONTACT: Rachel Knudson, R.N., EMS Training, Hennepin County Medical Center, 701 Park Avenue South, Minneapolis, MN 55415; 612/347-3638.

Oct. 7 **Glaucoma Course** HealthSpan; Phillips Eye Institute, Minneapolis, MN. CONTACT: Michelle Hemingway, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/336-5061.

Oct. 7-8 **Family Practice Update** HCMC/HFA Office of Academic Affairs/U of M; Mall of America Grand Hotel, Bloomington, MN. CONTACT: Ann Samways, CME Coordinator, 612/347-2078, or Robin Hoppenrath, Manager, Office of Academic Affairs, 612/337-7128.

Oct. 8 **Current Trends in Ophthalmology** HealthSpan; Hotel Sofitel, Bloomington, MN. CONTACT: Michelle Hemingway, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/336-5061.

Oct. 12-15 **Thoracic Organ Transplantation** Minneapolis Heart Institute Foundation; Westin La Paloma, Tucson, AZ. CONTACT: Don Young, 2810 57th Avenue North, Minneapolis, MN 55430; 612/574-7982.

Oct. 13-15 **Annual Orthopedic and Trauma Seminar** HCMC/HFA Office of Academic Affairs/U of M; Pillsbury Auditorium, HCMC. CONTACT: Laura Carroll, Orthopedics, Hennepin County Medical Center, 612/347-2075, ext. 3736.

Oct. 14-15 **Cutaneous Laser Surgery** HealthSpan; Abbott Northwestern Hospital, Minneapolis, MN. CONTACT: Don Young, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

Oct. 15-16 **International Symposium on Myeloproliferative Disorders** Mayo Foundation; Siebens Medical Education Building, Rochester, MN. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 507/284-2509.

Oct. 21 **Third Annual Conference for CME Planners** Minnesota Medical Association; Northland Inn, Brooklyn Park,

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MN. CONTACT: Jane Phillip, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875 or 800/999-1875.

Oct. 23-27 **Advances in Diagnostic Radiology** Mayo Foundation; Sea Island, GA. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Oct. 24-25 **Advanced Trauma Life Support (ATLS)** HealthSpan; United and Children's Hospital Conference Center, St. Paul, MN. CONTACT: Annette Carlson, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7910.

Oct. 27-28 **Trauma Management for Primary Care Providers** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Oct. 28 **ECG Conference** HCMC/HFA Office of Academic Affairs/U of M; Mall of America Grand Hotel, Bloomington, MN. CONTACT: Ann Samways, CME Coordinator, 612/347-2078, or Robin Hoppenrath, Manager, Office of Academic Affairs, 612/337-7128.

Oct. 28-29 **New Ulm Fall Seminar** HealthSpan; Holiday Inn, New Ulm, MN. CONTACT: Don Young, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

NOVEMBER 1994

Nov. **Annual A. B. Baker Dinner Lecture** HCMC/HFA Office of Academic Affairs/U of M; Date and location to be announced. CONTACT: Ann Samways, CME Coordinator, 612/347-2078, or Robin Hoppenrath, Manager, Office of Academic Affairs, 612/337-7128.

Nov. 4-5 **Front Line Neurology: Primary Care Management of Patients with Neurological Problems** HealthSpan; Marriot City Center, Minneapolis, MN. CONTACT: Don Young, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

Nov. 10-12 **Strategies in Primary Care Medicine** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Nov. 11-13 **Clinical Mycology** Mayo Medical Laboratories; Mission Inn, Howey-In-the-Hills, FL. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Nov. 18 **Urogynecology for Primary Care** HCMC/HFA Office of Academic Affairs/U of M; Location to be announced. CONTACT: Ann Samways, CME Coordinator, 612/347-2078, or Robin Hoppenrath, Manager, Office of Academic Affairs, 612/337-7128.

Nov. 18-19 **Point-of-Care Testing/Phlebotomy** Mayo Medical Laboratories; The Stouffer Madison, Seattle, WA. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

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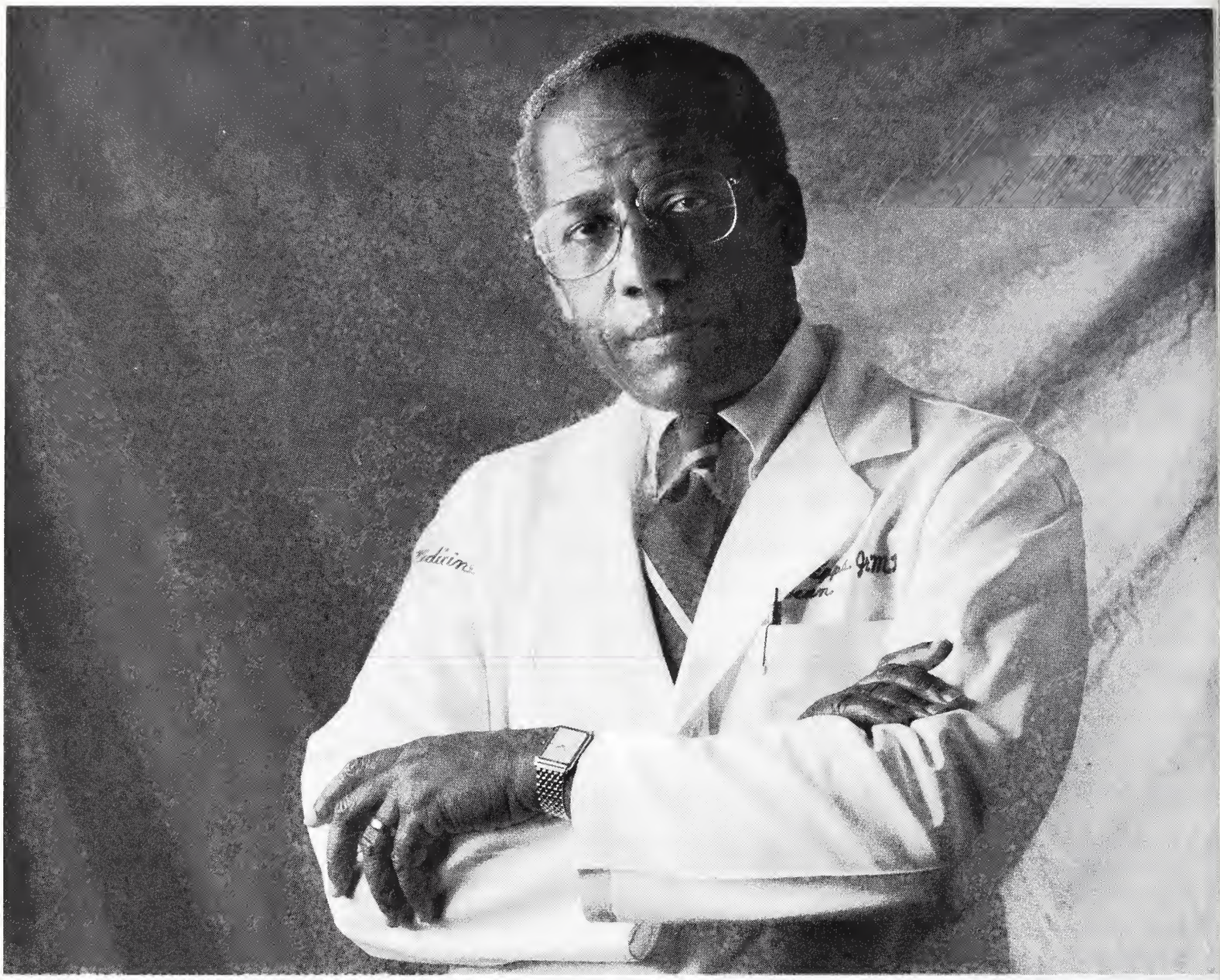

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Physician Opportunities and Miscellaneous Listings

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- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

General Surgeon, Ob/Gyn, Internal Medicine to join progressive 13-physician group practice. Rural college town 30 miles from St. Paul, Minnesota. New clinic and new hospital. Contact: Robert B. Johnson, M.D., River Falls, WI 54022; 715/425-6701. (*5/94-R)

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Family Physicians, P.A., 612/835-3609, or send inquiries to 7801 East Bush Lake Road, Suite 400, Bloomington, MN 55439. (*3/93-R)

Mankato Clinic, Ltd. is seeking additional BC/BE physicians in the following specialties: orthopedics, radiology, invasive cardiology, oncology/hematology, family practice, and general internal medicine. The Mankato Clinic is a 59-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. M. P. Wheeler, President, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (10/93-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

BC/BE Internal Medicine and Ob/Gyn Physician: Excellent opportunity to join a well-established, progressive, 26-physician multispecialty group located in an economically sound community of 22,000 (drawing area of 45,000), 65 miles south of the Twin Cities. Full membership after one year. Competitive salary and fringe benefits package. Contact Craig Oien, M.D., or Terry Tone, Administrator, 134 Southview, Owatonna, MN 55060; 507/451-1120. (9/92-R)

Forest Lake Doctor's Clinic is seeking a BC/BE family physician and ob/gyn to join a growing 12-physician multispecialty practice. Located 25 miles north of Twin Cities in progressive community with excellent schools, outstanding recreational activities. Hospital located across street from clinic. Respond with CV or call Doug Sill, M.D., Harvey Frank, M.D., or Geoff LaGary, Administrator, 121 SE 11th Avenue, Forest Lake, MN 55025; 612/464-7100. (11/92-R)

Olmsted Medical Group is seeking BC/BE physicians in the following specialties: orthopedics, radiology, family practice, emergency medicine, and ob/gyn. Great opportunity for well-trained physicians to join a 55+ physician multispecialty group in a dynamic, progressive practice. In addition to the main office in Rochester, the group operates eight branch offices in southeastern Minnesota. Excellent salary/benefits package includes malpractice insurance, flexible benefits plan, 401(k) and profit sharing, and relocation assistance. Send CV to Olmsted Medical Group, Attn: Susan Schuett, 210 Ninth Street SE, Rochester, MN 55904. (1/92-R)

Internal Medicine and Dermatology practice opportunities available at the Faribault Clinic. The Faribault Clinic is a multispecialty group practice of 18 physicians. Faribault is located 50 miles south of Minneapolis on I-35. For more information contact Ray W. Wood, M.D., or Ken Smith, Administrator, 924 NE First Street, Faribault, MN 55021; 507/334-3921. (4/94-R)

Stillwater: 20-physician multispecialty group with emphasis on primary care seeking BC/BE family physician. Scenic location with excellent school system, supportive medical community with strong local hospital, competitive salary and benefits. Send CV to Jon Pedersen, St. Croix Valley Clinic, 921 South Greeley, Stillwater, MN 55082; 612/439-2215. (9/93-R)

Family Physician wanted to join six-physician, three-P.A., two-site family practice group in St. Anthony and Shoreview. Obstetrics available. Competitive salary, benefits package, and call schedule. Contact Gerald Pitzl, M.D., Silver Lake Clinic PA, 612/788-9251. (7/91-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

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Mora, Minnesota: Aggressive, young, seven-physician family practice group seeks to add one or two physicians. Mora is a friendly community located one hour north of Minneapolis/St. Paul. There is abundant outdoor recreation in the area, including Mille Lacs Lake. The town is host to the Vasaloppet Ski Race, a half-marathon, canoe race, and bike race. If you are interested in this practice opportunity, and you should be, please contact Peter J. Donner, M.D., Mora Medical Center, Ltd., Mora, MN 55051; 612/679-1318 (wk); 612/679-1981 (hm). (11/92-R)

St. Paul, Minnesota: The East Metro Community Health Network is seeking part/full-time family practice physicians with interest in community-based health care. Attractive hours, salary, and benefits. Call Pamela Page, 612/266-2515, to discover more about this unique opportunity. Send CVs to EMCHN, 50 West Kellog Boulevard, Suite 930, St. Paul, MN 55102. *1-5/94

Internist/Geriatrician

Here's your opportunity to join a physician/nurse practitioner group in staffing a 110-bed Extended Care/Subacute Care program at the Minneapolis VA Medical Center. Resident teaching opportunities and limited call. For additional information contact:

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Medical Director
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ASSOCIATE MEDICAL DIRECTOR

A challenging opportunity to play a significant role in shaping and carrying forward continuous quality improvement activities as they pertain to physician peer review is now available. The Foundation for Health Care Evaluation (FHCE), Medicare's Peer Review Organization for Minnesota, is seeking a part-time physician (20 hours/week) for the position of Associate Medical Director. This person will direct our internal monitoring program for Physician Peer Reviewers; perform internal monitoring evaluations; review and respond to staff, practitioner, and certain provider inquiries; assist the Medical Director in policy development, education, and special assignments; and serve an overall medical support function within the organization and through various outreach activities.

The successful candidate will be a board certified physician, preferably a family practitioner or internist, with a minimum of five years patient care, proven management expertise, strong organizational skills, and excellent communication skills—both written and verbal. Some experience in the quality assurance and/or review area is desirable.

FHCE hopes to fill this position immediately. The deadline for applications is May 31, 1994. FHCE offers a competitive salary and excellent benefits. Please submit résumés to:

C. Corbett
Director, Human Resources
FOUNDATION FOR HEALTH CARE EVALUATION
2901 Metro Drive, Suite 400
Bloomington, MN 55425

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Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Edina, Lakeville, Bloomington, and/or at the Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/835-3609, or send inquiries to 7801 East Bush Lake Road, Suite 400, Bloomington, MN 55439. (*3/93-R)

Wisconsin—Family Practitioner Needed by progressive and growing group practice in west-central Wisconsin city of 60,000. Ninety miles from Minneapolis/St. Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high-quality care in a good recreational area. Send CV to James A. Volk, M.D., Medical Director, PO Box 3217, Eau Claire, WI 54702-3217; 715/836-8552. *3-6/94

General Surgeon, BC/BE, to join progressive 24-physician multispecialty group practice. Rural setting with metropolitan practice style, 25 miles from Minneapolis. Group has excellent reputation and large geographical referral area. Recently expanded facility is adjacent to newly remodeled 110-bed hospital. Comprehensive benefits package with excellent remuneration. Interested surgeons should contact Donald E. Somers, M.D., Lakeview Clinic, Ltd., 424 State Highway 5 West, Waconia, MN 55387; 612/442-4461. AA/EOE. 3-6/94

Full-time Family Physician for outpatient family practice clinic. No obstetrics, ER, or hospital responsibilities. Very progressive north lakes practice located in Pine River, Minnesota. Competitive salary. Send CV or call Carolyn Bridge, Pine and Lakes Clinics, PO Box 88, Pine River, MN 56474; 218/587-4416. 2-6/94

Internal Medicine—Twin Cities/Northwestern Suburbs: Busy, young, four-physician practice. Excellent salary and benefits for the right BC/BE physicians interested in all aspects of internal medicine. Growing hospital and clinic practice expanding to new site. No management duties or buy-in required. Send CV/call Lex Nerenberg, M.D., Bass Lake Physicians, PO Box 29188, Minneapolis, MN 55429; 612/537-6022. (3/93-R)

Northern Michigan: Excellent opportunities for BC/BE physicians in family practice, internal medicine, neurology, psychiatry, and gastroenterology to establish practices in a recreational, northern-Michigan, family-oriented community. Salary guarantees with excellent benefits. Send CV or contact Susan Khoury, Dickinson County Memorial Hospital System, 400 Main Street, Norway, Michigan 49870; 800/236-3240. *3-5/94

Mankato, Minnesota: FP needed to join group of five board-certified family physicians aged 36 to 46 in fast-growing, full-range practice. Ob optional. Population approximately 40,000. Seventy miles to Twin Cities. Five colleges nearby. Subspecialty consultation readily available on hospital staff. Academic appointment available. Call Gregory Kutcher, M.D., or Linda Dulas, Clinic Manager, 1695 LorRay Drive, North Mankato, MN 56003; 507/387-8231. (*4/94-R)

Pediatrician—BC/BE: Premier pediatric group in affluent suburbs of Twin Cities has unusual opportunity for new members. Fringe benefits and compensation well above average. Contact: Sally Vissers, Metropolitan Pediatric Specialists, P.A., 6545 France Avenue South, Suite 510, Edina, MN 55435-2186; 612/920-9191. 3-7/94

Family Practice, Emergency Medicine, Internal Medicine, Locums, Ob/Gyn, Occupational Medicine, Pediatrics, Urgent Care opportunities available in Minneapolis/St. Paul and leading communities within a 150-mile radius of the Twin Cities. Contact HealthSpan, Physician Services, 2810 57th Avenue North, Minneapolis, MN 55430; 800/248-4921 or 612/574-7627. *3-6/94

Family Physician: Tired of call? Want predictable hours? Full-time physician needed to work three days per week in our ambulatory care centers located in Roseville, Minnetonka, and Eagan. Salary $80,000 minimum and benefits package including malpractice insurance. Also, looking for part-time physicians to cover for Sundays and vacations. Contact Cara Auge or William Wenmark, c/o NOW Care Medical Centers, 13031 Ridgedale Drive, Minneapolis, MN 55305; 612/593-9010. (10/93-R)

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Tropical Medicine/International Health: Large primary care clinic for refugees and immigrants in St. Paul, Minnesota, looking for internist with experience and expertise in cross-cultural health care, tropical and travel medicine. Clinic sees patients from around the world, with emphasis on Southeast Asians, Russians, Hispanics, and Africans. Overseas experience and bilingual/bicultural providers preferred. Contact: Patricia F. Walker, M.D., Lead Physician, International Clinic, Ramsey Clinic, Department of Internal Medicine, 640 Jackson Street, St. Paul, MN 55101; 612/221-2852. Fax: 612/221-3048. 1-5/94

Family Practice Physician needed to join established group of five FPs and one pediatrician in northwestern Wisconsin community of 8,000 with service area of 40,000—located on the doorstep of Wisconsin's fabulous lake country. Practice medicine in a small, family-oriented community within two hours of Minneapolis/St. Paul. Competitive salary and excellent fringe benefits. Send CV to James Volk, M.D., Medical Director, PO Box 3217, Eau Claire, WI 54702-3217; 715/836-8552. *3-6/94

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Wisconsin: 20-physician primary care group is seeking fourth BC/BE internist. Practice the full spectrum of internal medicine. City of 60,000 in west central Wisconsin, 90 miles from Minneapolis/St. Paul. Competitive salary and excellent fringe package. Contact James Volk, M.D., Medical Director, Group Health Cooperative, PO Box 3217, Eau Claire, WI 54702-3217; 715/836-8552. *3-6/94

Hazelden Foundation, founded in 1949 and headquartered in Minnesota, is seeking a Medical Director to promote continuous quality improvement of medical care; promote continuous upgrade of medical knowledge, skill, and attitudes relevant to chemical dependency; ensure corporate-wide quality medical service practice; provide ongoing medical leadership; participate in clinical responsibilities with patients and in agency outreach efforts per the strategic and marketing plan as opportunities arise. Qualifications: M.D. with extensive experience in chemical dependency/rehabilitation, psychiatrist preferred; unrestricted license to practice in the state of Minnesota; licensed or eligible by knowledge/experience by the American Society of Addiction Medicine. Direct experience in the field of chemical dependency preferred in addition to having knowledge and commitment pertaining to the Minnesota Model of recovery; strong communication presentation skills and team player necessary. Must have had two years freedom from chemical use/abuse and must not have been convicted of a felony in the last seven years (per Minnesota Department of Human Services licensing). Qualified candidates send letter and résumé to Hazelden Foundation, Human Resources, PO Box 11, Center City, MN 55012. EOE. 1-5/94

Minneapolis: BC/BE family practice physicians needed to join the Family Practice Department of a 376-physician multispecialty clinic in desirable Twin Cities area. Currently, we have positions available at our Brooklyn Center, Burnsville, and Shakopee offices. Salary and benefits are highly competitive. For additional information contact Patrick Moylan, or send CV and letters of inquiry to Physician Recruitment, Park Nicollet Medical Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3286. Fax: 612/924-2819. *2-5/94

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Third Annual Clinical Neurology and Behavioral Sciences Symposium: Acute Neurological and Psychiatric Illness: Friday, May 20, to Sunday, May 22, 1994, Landmark Resort and Conference Center, Egg Harbor, Wisconsin. Contact: Marshfield Clinic, Office of Medical Education, 1000 North Oak Avenue, Marshfield, WI 54449; 800/541-2895. 2-5/94

Orthopedic Surgery—West Central Minnesota: 90+ physician multispecialty group is currently looking for two BC/BE orthopedic surgeons to join a busy three-person orthopedic department. A large 55+ physician primary care department ensures an active and interesting practice. Affiliated Medical Centers, headquarterd in Willmar, Minnesota, serves a population of more than 220,000 from eight locations in west central Minnesota. Organization offers an attractive and competitive salary and benefits package. Contact John P. Merickel, M.D., Recruitment Director, Affiliated Medical Centers, P.A., 101 Willmar Avenue SW, Willmar, MN 56301-3591; 612/231-5050. 2-6/94

Wisconsin—Third BC/BE Obstetrician/Gynecologist needed to join stable, progressive, primary-care-based HMO/group practice in university town of 60,000 near Minneapolis/St. Paul. Excellent quality of life and outstanding recreational area. Competitive salary and fringe benefits. Contact: Medical Director, Group Health Cooperative, PO Box 3217, Eau Claire, WI 54702-3217; 715/836-8552. *3-7/94

University of Minnesota School of Dentistry invites applicants through 6/30/94 for part-time, non-regular faculty for consultative diagnostic and treatment planning services in specialty clinics. M.D. required, with training and experience in otolaryngology or reconstructive surgery cleft palate patient care. Faculty rank dependent upon experience and training. Send résumé indicating specialty or area(s) of clinical expertise to Dean Richard P. Elzay, University of Minnesota School of Dentistry, 515 Delaware Street SE, Minneapolis, MN 55455. The University of Minnesota is an equal opportunity educator and employer. 1-5/94

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Family Practice Opportunity: Minnesota's North Shore offers a unique lifestyle and an opportunity to work in well-established, growing, community clinic. Board certified family practitioner needed to complete physician group. Student loan repayment program, competitive compensation, benefits package. Services include low-risk obstetrics and ER coverage. Flexible hours. Hospital/nursing home locally. Contact Rita Plourde, Executive Director, Cook County Community Clinic, Grand Marais, MN 55604; 218/387-2330. 3-7/94

NEW ADVERTISING RATES

Effective with the July 1994 issue of *Minnesota Medicine*, classified advertisements will be billed at the rate of $2 per word with a $50 minimum.

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Minnesota Medicine

Published monthly by the Minnesota Medical Association

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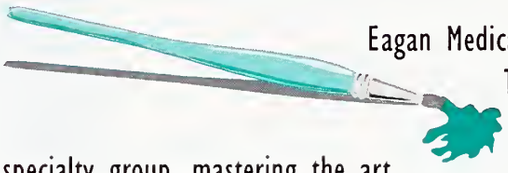

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Medical Map-Making

Charles R. Meyer, M.D.

My first hobby was collecting maps. Driven partly by wanting to know where things were and partly by the lure of the colored lakes and highways, I rapaciously scoured gas stations in my Illinois neighborhood looking for the rare station that had an Arkansas map. That hobby faded when free maps at gas stations went the way of 30-cents-per-gallon gasoline. But map collecting is *in* again in medicine. Medical maps are called guidelines, pathways, parameters, or algorithms, and the AMA has collected 1,600 in its latest compendium. In this *Minnesota Medicine,* we take a ride down those guideline highways and try to understand the who, what, and why of practice parameters.

Practice parameter efforts at the local level (Fairview hospitals), state level (MCCAP and Minnesota Department of Health), and national level (AHCPR) are featured. Catherine Borbas provides an update on the Minnesota Clinical Comparison and Assessment Project (page 12), which was started in 1989 as a collaborative effort of multiple Minnesota hospitals and physicians. MCCAP does not just churn out expert panel guidelines and walk away. Clinical data and outcomes are monitored, and the guidelines are then tweaked based on those outcomes. The clinical pathway project at Fairview as described by Dr. Robert Meiches (page 9) also feeds back data derived from experience to continuously improve pathways to promote quality care. Greg Gifford details the current status of practice parameters developed under MinnesotaCare legislation on page 15, and the MMA's Position Paper on Practice Parameters appears on page 20.

It seems everybody is saying practitioners need guidance. Have we lost our way, abandoning the clear directives of medical school and residency, straying fugue-like into uncharted country roads? Why have all these highway helpers popped up uninvited to tell us which way to go?

"In this issue, we take a ride down guideline highways and try to understand the who, what, and why of practice parameters."

First is the bottom line. Let's be clear—the clarion call for quality and consistency would be a meek mumble were the health care dollar not escalating by double digits each year.

Second, medical practice is not consistent. The widely quoted studies of Wennberg document vast variation in rates of common surgical procedures in geographically proximate locations (New Haven and Boston, for example). Explanations range from "some doctors are greedier" to "some doctors are dumber." The most plausible hypothesis is professional uncertainty. One estimate suggests that 80 percent to 90 percent of common medical practices have no basis in scientific fact. Whether or not that estimate is close, most physicians would concede that the majority of diagnoses they make do not have the scientific solidity of a geometry proof.

Third, we need a method for assessing our progress. Do we improve with experience? We must approach improvement scientifically. Do I know why I select a particular anti-hypertensive medication? Do I know what's happened to the last 10 patients to whom I gave it? Only vaguely. Many guidelines contain the disclaimer-like statement that the physician's clinical judgment may dictate actions that deviate from the guideline. Practice parameters should not replace clinical judgment but should improve how it's nurtured. Parameter pushers are suggesting that maps drawn by experts will help us do this more rationally.

Will a parameter-mapped landscape be a better one? The MMA Position Paper contains a healthy dose of skepticism, rightly pointing to the perils of inflexible imperatives. It also raises the legitimate, unanswered question about future use of guidelines in the courtroom. Physicians don't yet know whether parameters will serve as a friend or foe in malpractice defense.

Parameters will be inflexible and inoperable if they are standards emerging on stone from the burning bush of experts. But if they develop as living, *modifiable* guides based on the weight of current knowledge, and if they are designed to seamlessly and helpfully meld into a practitioner's day, then they are a worthy effort. In the future, we should decide which way to turn based not on our faulty memory of what the tree on the corner looks like, but on a well-devised map drawn by experts and updated by their, and our, experience. MM

Administering Quality Medicine

Dr. Jean Harris has been at the leading edge of health care since the late 1960s as an internist, teacher, politician, and administrator. Now she's turned her sights on quality management and outcomes measurement.

By James Bohen

When Jean L. Harris, M.D., went to work at the University of Minnesota Hospital and Clinic (UMHC) just over two years ago, the prominence of academic medical centers was being challenged. The facility was beginning long-range strategic planning and everyone was talking about quality management, cost containment, service improvement, and outcomes assessment. That Harris was at the center of change was hardly surprising. In a career that's included sitting on presidential commissions, administering a state department with a $2.3 billion budget, commuting between coasts, receiving numerous awards, and raising a family, she has always, in her words, "managed to catch the wave."

As senior associate director and director of medical affairs, Harris oversees UMHC's outcomes management program. She is also involved in implementing a continuous quality improvement program for patient care and administration. Recently named one of seven heroines of health care by the Minnesota Women's Consortium, this self-described "people person" is "attracted to the challenge of bringing skills to bear on the great forces changing health and social services."

A History of Trail-blazing

Harris has welcomed challenge throughout her life. In the early 1950s, this Richmond native was the first African-American to attend and graduate from a Virginia postgraduate institution. Her "great adventure," as she calls it, has also included being the first African-American intern and medical resident in Virginia. Her trail-blazing cleared the path for many other students of color at the Medical College of Virginia (now part of Virginia Commonwealth University), which recently established an endowed fund in her name to help minority students attend VCU's undergraduate and medical schools.

In 1960, Harris settled into private practice in internal medicine in Washington, D.C., and began teaching at Howard University's College of Medicine. She married Leslie Ellis, now retired after a career as a Richmond health care administrator. They have three daughters.

With the advent of President Lyndon Johnson's "Great War on Poverty," Harris found the lure of administration irresistible. "You could just feel the electricity in the air," she says of that time, "and it was that heady excitement that started me to shift from thinking of myself as a practitioner of medicine on a one-on-one basis to a one-to-millions basis."

From her first administrative position as a bureau chief in the

"By measuring the results and comparing them against our guidelines and pathways, we are ultimately able to manage outcomes, which is the real goal."

–*Jean Harris, M.D.*

District of Columbia's health department in 1967, Harris's life got extremely complicated. For the next six years—often simultaneously—she taught in the medical schools of Howard, Johns Hopkins, and UCLA; was executive director of the National Medical Association Foundation; was a consultant to the U.S. Agency for International Development, the National Institutes of Health, the U.S. Department of Health and Human Services, and Congress; was actively involved in various civic groups; and kept up a part-time practice. In later years, she served as Virginia's secretary of human resources, becoming the first African-American and the first woman to serve in that state's cabinet.

The Move to Minnesota

After completing her four-year term in Virginia's cabinet in 1982, Harris made her way to Minnesota, accepting a job as a Control Data vice president. But after six years, during which she was named one of America's Top 100 Black Business and Professional Women by *Dollars & Sense* magazine, she began to miss medicine.

During her next four years, as president and CEO of the Ramsey Foundation (now merged with St. Paul-Ramsey), Harris began adapting quality management ideas to the health care field. She had seen quality management in action at Control Data and believed it could be applied to health care. Her next move, to the university, seemed a natural segue. "At Ramsey, we considered ourselves the teaching arm of the University of Minnesota Hospital in the east-metro area," she notes. "Coming to the university offered me a chance to become more involved in developing concepts of quality improvement in health care."

The University of Minnesota Challenge

Harris believes academic medical centers have "replicated" themselves so well that community hospitals now have the personnel and technology to do many of the same things university hospitals do. While academic medical centers remain the premier sites for research and for training future health care professionals, they also have to survive in today's increasingly competitive market. "Academic medical centers have always said their patients are far more complex than those of traditional community hospitals," says Harris. "Now we must document that old adage. We must demonstrate the complexity of the problems we treat and the excellent results of the care patients receive from us."

Quality of care must be defined before it can be demonstrated—and that's not easy to do. Harris and

HARRIS continued on page 32

ILLUSTRATIONS BY LIZ MONSON

Map collecting is in again in medicine. Medical maps are called guidelines, pathways, parameters, or algorithms. In the following series of articles, Minnesota Medicine takes a ride down those guideline highways to try to understand the "who, what, and why" of practice parameters.

Practice parameters

Fairview's Clinical Pathway Project

Fairview has implemented 13 clinical pathways to date and is collecting data to assess their impact on quality of care.

By Robert K. Meiches, M.D.

The past few years have brought about an intense focus on quality improvement and an explosion of projects aimed at improving the quality of health care. The Clinical Pathway Project at Fairview Hospital and Healthcare Services is one such initiative. Its development and implementation have been supported by clinicians and managers throughout the Fairview organization, and like all new projects, it has relied upon the experience of forerunners. This overview highlights the history of the project, including its implementation and current status, as well as some of the project's successes and challenges associated with quality innovation.

History

In late 1991, Fairview established a task force to review the need to develop a tool known in the industry as "clinical progressions" (clinical care maps or anticipated paths of recovery). The initiative grew from two sources: 1) a senior management team's interest in replicating the experience of groups throughout the country that had used clinical progressions to significantly cut length of stay and costs associated with acute inpatient hospital services; and 2) the quality improvement movement, à la Deming and Juran. Clinicians became interested in using continuous quality improvement (CQI) techniques to improve the quality of care by identifying and addressing variation while, ideally, reducing costs at the same time. The task force recommended the Clinical Pathway Project to the Fairview system in mid-1992. The primary objectives of the project were to improve quality of care by examining processes and outcomes, decreasing financial risks, improving professional collaboration, and increasing competitive advantage. Table 1 on the following page lists additional benefits Fairview anticipates.

The term "clinical pathway" refers to a tool that describes the sequential steps or processes that represent the best known care for any given clinical situation. Fairview leaders envisaged that the project would identify clinical conditions and implement pathways, not only in acute-care hospitals, but within clinics, home care, and nursing homes, then link the pathways to provide a seamless continuum of care. Fairview would set up multidisciplinary clinical pathway teams of physicians, nurses, pharmacists, and all other clinical disciplines involved in patient care. The project would measure traditional clinical outcomes (morbidity, mortality, etc.) and would assess patient satisfaction and functional status, cost, and variation in key clinical processes. The Fairview system could use these outcomes externally for contracting and marketing and internally to identify opportunities to improve the quality of care.

Once the project gained the support of clinicians and managers, the Fairview system allocated significant financial and human resources to begin implementation. Fairview appointed clinical pathway coordinators to shepherd the clinical pathways and built an organizational structure to support the project throughout the Fairview system.

Clinical pathway teams developed pathways incorporating "best known practices" from reviews of the literature and the knowledge base within the organization. Fairview then conducted pilot tests of these pathways and initially implemented them in three of its acute-care hospitals.

Progress to Date

Thirteen pathways have been implemented to date, six of which are operating throughout the Fairview system (see Table 2 on the following page). All clinical pathways are identified and implemented using a quality improvement process (see Table 3) that focuses on fully understanding and clarifying desired outcomes (key quality characteristics) and the variables that influence this quality (key process variables). Once the pathway is written and implemented, data collection identifies the key process variables and their impact on the overall quality of care.

continued

The Program's Successes

Many of the program's successes are a result of improved integration of care. Examples include a better understanding of customer needs that help identify and direct quality efforts, the establishment of effective multidisciplinary teams, and the creation of uniform clinical pathways across Fairview. Variation found in our initial analysis led us to improve the coordination of admit orders and educational programs. Preliminary data on

Table 1

Anticipated benefits of Clinical Pathway Project

Quality

- reduced variation in clinical processes
- increased consistency of service
- optimized resource utilization
- improved continuity of care
- increased patient satisfaction
- improved ability to identify and manage system barriers
- decreased frequency of unplanned readmission

Coordination

- accelerated development of continuum of care
- coordinated systems-billing, information systems, etc.
- improved consistency of service across Fairview, enhancing ability to contract with payers/employers

Communication

- improved ability to identify, communicate, understand, and act on paths of anticipated recovery
- improved collaboration among professional staff
- improved staff orientation and training
- decreased interdepartmental barriers
- improved patient and family education
- use of clinical pathways as an effective documentation tool

Measurement

- identification of measurable data points
- collection of key data to improve clinical and managerial decision making
- improved ability to track outcomes
- improved ability to compare efficacy of varied treatments

Table 2

Fairview's clinical pathways

System pathways implemented	Hospital pathways implemented	Pathways in development
• adult chemical dependency	• CVA (cerebrovascular accident)	• c-section
• coronary angiogram	• total knee replacement	• chest pain/angina
• coronary angioplasty	• spine surgery (cervical, lumbar, thoracic)	• pediatric asthma
• coronary artery bypass graft	• valve replacement	• congestive heart failure
• healthy newborn	• colon resection	• hemorrhoidectomy
• normal vaginal delivery	• radical retropubic prostatectomy	• rectal cancer
• total hip arthroplasty		

coronary artery bypass surgery show significant drops in ICU and hospital length of stay without increased complications (improved quality care at a lower cost). Data collection and analysis are in full swing for the first 13 clinical pathways, and over the next months, we should have a better idea whether we can identify variation and improve the quality of care.

As physicians, we often look for short-term solutions. However, it is far too early to tell whether resources invested in the Clinical Pathway Project will pay off. It will take several years before we can make data-based judgments about whether lasting improvements have occurred as a result of our efforts.

Table 3

Quality improvement process

Find	Identify case type
Organize	Organize group
Clarify	Define episode of care
Understand	Analyze practice pattern
Select	Set KQC (Key Quality Characteristics) and KPV (Key Process Variables)
Plan	Develop pathway
Do	Do pilot study and implement pathway
Check	Collect and analyze data
Act	Report and improve

Challenges

As with any innovation, the Clinical Pathway Project has faced significant challenges. Virtually every physician involved in the project has supported it conceptually, but many physicians are still skeptical. Some are concerned about "too much change too fast" and some perceive pathways as "cookbook medicine" or "interference in practice." Yet, support has grown as more physicians have become involved in clinical pathway teams and have begun to realize some of the project's benefits.

Lack of a well-coordinated clinical information system has hampered progress by requiring that clinicians "double document" on hospital charts, creating extra work and frustration in a system already choked by duplication. The "information" demands associated with this project have dramatized the need for clinical information systems and have nudged the formation of task forces to look at a wide array of information system-related areas.

Data management has also presented a major challenge to the project. The identification of data elements to be collected, collection tools, surveys used, and actual collection of information, particularly from physician clinics, have demanded our close attention. Efforts to appropriately focus data identification and collection and to use the clinical pathway tool itself as a means of data collection have been encouraging.

Partnership

Throughout the Clinical Pathway Project, Fairview has worked in partnership with the Employers Association, North Memorial, Prudential, HealthEast, the University of Minnesota, and the Healthcare Education and Research Foundation. This cooperation has allowed us to share resources and make faster progress in clinical pathway development.

Future

As the clinical pathway project begins to generate data, Fairview will be able to determine the true value of this initiative to the organization and the communities we serve. Clinical pathways will continue to change their shape and form over the years but will likely be important tools in the delivery of care. New and varied clinical quality initiatives will be required to complement the clinical pathways. In the short term, these will emphasize individual case management and will help guide the process of care for complex situations. We will refine our understanding of customer needs, allowing us to better focus our data collection for reporting and improvement purposes. Over the longer term, we hope to develop an automated information system, integrating clinical and financial databases. As we move into these new realms, physicians will continue to step forward, taking risks and clearing paths. MM

Robert Meiches is director of the Clinical Pathways Project at Fairview; a geriatrician/internist with Consultants Internal Medicine in Edina; and is a member of the Minnesota Medical Association Board of Trustees.

The Minnesota Clinical Comparison and Assessment Project

MCCAP is striving to improve quality of care for member hospitals and physicians by implementing clinical guidelines and testing them through outcomes research.

Catherine Borbas, Ph.D., M.P.H., C. Randall Nelms Jr., M.D., and Alvin Schultz, M.D.

The Minnesota Clinical Comparison and Assessment Project (MCCAP), implemented under the auspices of the Healthcare Education and Research Foundation, is a consortium of hospitals and physicians working to improve health care by linking clinical practice guidelines with outcomes data. Four years ago, many people were skeptical that a consortium of physicians and competing health care institutions could effectively implement or sustain a voluntary, grassroots quality improvement program. Despite such doubts, MCCAP now includes 53 Minnesota hospitals and is the largest and most comprehensive quality evaluation and improvement program of its kind in the country. The program is almost completely funded by the Agency for Health Care Policy and Research and the National Cancer Institute through collaboration with Harvard Medical School.

Since 1989, MCCAP has tested the feasibility of implementing a program that links clinical guidelines with analysis of clinical data and patient outcomes information to help clinicians and health care systems evaluate and improve their services. The MCCAP experience could be helpful in the current national health care debate, which often cites guideline development and outcomes management as key quality improvement tools.

Uses of MCCAP Outcomes Data

MCCAP provides member hospitals with many essential tools for quality of care evaluation and improvement (see sidebar on facing page). Member hospitals have used MCCAP in various ways, but primarily as a shared resource for comparative quality of care information. Most hospitals have used MCCAP's data to develop quality improvement projects.

MCCAP has collected pre-admission, inpatient, and post-discharge patient outcomes information on 3,500 elective cholecystectomy patients and 2,000 total hip replacement patients. It has provided clinicians with such information as the amount of time required for patients to return to their normal activities, the degree to which patients gain relief from their initial symptoms after treatment, and patients' overall satisfaction with their medical treatment. Because clinicians have not routinely had access to such standardized information, they have not been directly aware of what happens to many patients after treatment. For example, many surgeons were surprised to learn that 24 percent of patients in the MCCAP study had symptoms after surgery that closely resembled their pre-surgery symptoms. This prompted the physicians to re-evaluate the MCCAP indications for cholecystectomy (adapted from the Rand criteria[1]) and recommend that they possibly be tightened.

Many MCCAP hospitals have developed quality improvement teams to address potential areas for improvement identified by MCCAP. For example, one hospital's patients reported significantly longer recovery periods after both open and laparoscopic cholecystectomies. MCCAP staff evaluated patients' illness severity, complications, discharge status, and post-discharge outcomes and concluded that these differences in recovery times did not occur for clinical reasons. Consequently, this hospital is reviewing its patient education program to ensure that patients are given realistic information about recovery time. The hospital is also evaluating whether patients are being influenced by their employers' sick leave policies.

Outcomes information also is essential for evaluating the appropriateness of treatment. When clinicians are presented with information on the appropriateness

of specific therapies or procedures, both inpatient and post-discharge patient outcomes information must be included. Otherwise, the clinicians do not readily accept guideline recommendations about the appropriateness of certain treatment methods and procedures. The linkage between treatment methods and their impact on patient outcomes has to be demonstrated.

For example, at feedback sessions, surgeons questioned MCCAP guideline recommendations regarding the use of cholangiograms. A comparison found that cholangiograms performed in concordance with MCCAP guidelines resulted in a much higher proportion of findings, e.g., bile duct stones and biliary stricture, than those not performed in concordance with the guidelines. Given this additional information, clinicians responded more positively to the MCCAP guideline recommendations, and many hospitals initiated quality improvement teams to change cholangiogram use.

Participation in MCCAP has enhanced the routine quality assessment and improvement activities at member hospitals. For example, most quality assessment programs tend to look at "average occurrences," such as average length of stay and average resource use by physician, and attempt to bring "outliers" closer to the average. But is the average always right? The figure (following page) shows the average use of cholangiograms and what the rate should be if they were performed in accordance with MCCAP guidelines and outcomes information. The marked difference between the two rates corresponds with an annual cost difference ranging from $812,000 to $1.2 million (see table on the following page). This variance underscores the importance of using guidelines and outcomes data to improve typical quality of care evaluations.

Overall, clinicians describe MCCAP as a useful and effective resource for quality improvement. John Kleinman, M.D., vice president of Medical Affairs at Unity Hospital, says, "The MCCAP information is useful in that it has enabled us to ask the 'why' questions. MCCAP has shown us that outcomes of elective cholecystectomy patients who receive prophylactic antibiotics are not different from the outcomes of patients who do not receive prophylactic antibiotics. We are now asking ourselves 'Why are some of us ordering prophylactic antibiotics in all cases of elective cholecystectomies?' "

Kleinman emphasizes the increased credibility and value of MCCAP guidelines because they are tested and revised after outcomes data are collected and analyzed. He says, "Dissemination of practice guidelines that are untested [by outcomes management and best practice experience] is like putting a new drug on the market that has not been tested and assuming it will have some benefit. This has tremendous impact at the national level since the majority of guidelines remain untested."

Fairview Hospital and Healthcare Services has been using MCCAP studies as a resource for its continuous quality improvement (CQI) programs, including its Clinical Pathway Project (see related article, page 9). Paul Bowlin, M.D., corporate medical director, says MCCAP is of value to the Fairview medical staff for the following four reasons: "1) The MCCAP elective cholecystectomy database is large and rich in information; 2) The project readily lends itself to quality improvement efforts; 3) It tells us where we are OK and helps us identify where we need to educate and re-measure; and 4) It lifts the cloud of confusion and narrows the mass of data to small, specific areas we can handle."

What MCCAP Provides Its Members

- Locally developed and reviewed clinical practice guidelines for selected conditions and procedures and a mechanism for local review and endorsement of nationally developed guidelines.
- A standardized data collection system across member hospitals to gather medical record information and survey patients before and after treatment.
- Severity-of-illness adjustment methods developed by nationally respected researchers, reviewed by local clinicians, and adapted for use.
- Comparative inpatient and post-discharge appropriateness and outcomes information.
- Comparative information on individual hospital compliance with guideline recommendations.
- On-site presentations where practicing clinicians are helped to evaluate and present their hospitals' results compared with the aggregate data.
- Mechanism to offer benchmark assessments for individual hospitals.
- Mechanism to bridge the gap between health care services research and health care delivery to facilitate application of research.

MCCAP Evolution

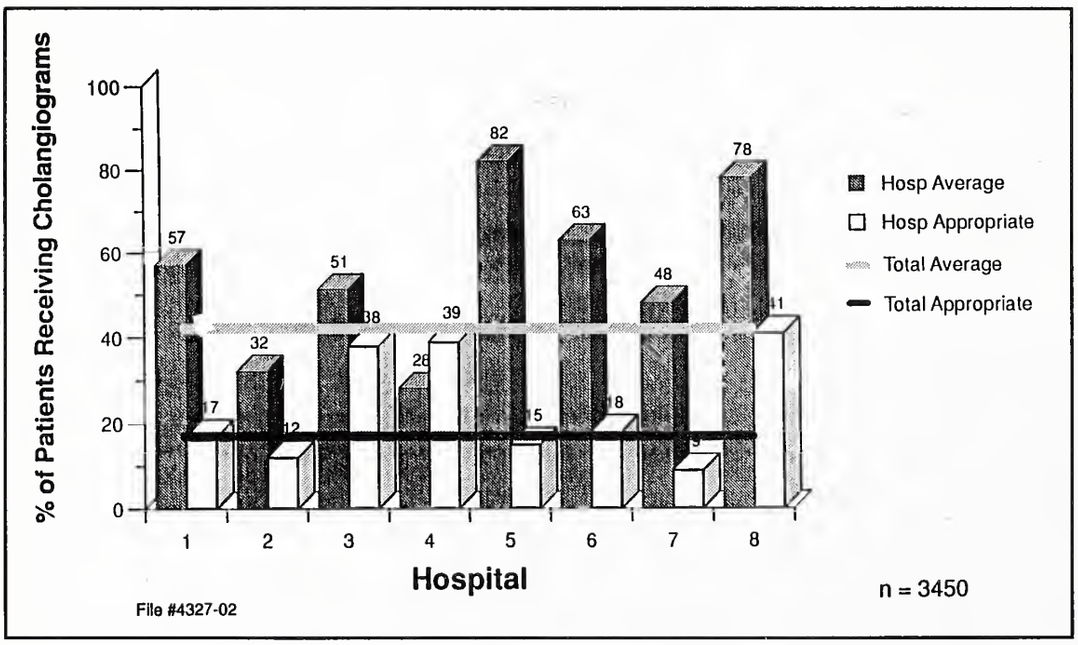
Like the Fairview system, other hospitals (North Memorial Medical Center, the HealthEast hospitals, the University of Minnesota Hospital and Clinic, and Unity Hospi

tal) will be using their findings from the MCCAP elective cholecystectomy study to form clinical pathways teams to discuss potential opportunities to improve quality. These pathways programs will be used not only internally to improve quality, but also will provide comparative clinical and patient-generated information to the Prudential Plus "Innovation Program" for members of the Employers Association Inc.

MCCAP has had several other unanticipated applications. Many Minnesota health plans have adapted MCCAP guidelines for their own use. MCCAP has received national recognition, as evidenced by its collaboration on two federally funded projects with Harvard Medical School and numerous requests for materials and presentations from such national groups as the American Medical Association, the American Hospital Association, the Agency for Health Care Policy and Research, the Office of Technology Assessment, Congress, the Institute of Medicine, state medical associations, business coalitions, and state health system reform groups. Also, the Health Care Financing Administration has selected the MCCAP total hip replacement guideline and data collection instrument to be used as the basis for its Uniform Clinical Data Set total hip replacement algorithm.

Future Direction

Since its inception, MCCAP has gradually published more of its findings and has revised its original data policies to allow MCCAP members to provide data to their customers and purchasers. All MCCAP clinical evaluation and improvement interventions are applicable to other settings and to other clinical conditions and procedures. Therefore, planning is underway to expand MCCAP beyond the hospital setting to include clinics, ambulatory settings, and integrated service networks. MM



Figure—Use of cholangiograms by hospital.

Table

Costs of inappropriate cholangiograms

Number of patients receiving cholangiograms	1,422
Number of patients meeting cholangiogram appropriateness guidelines	610
Difference between guideline number and actual number	812
Intraoperative cholangiograms cost	$1,000 to $1,500
Net savings to 36 MCCAP hospitals	$812,000 to $1,218,000

Catherine Borbas is executive director of the Healthcare Education and Research Foundation (HERF). C. Randall Nelms, a former chair of MCCAP, is on the Executive Committee of HERF, is president of the Minnesota Medical Association, and is an otolaryngologist with Otolaryngology & Head and Neck Surgery, P.A., in St. Paul. Alvin Schultz, a retired internist, is director of MCCAP and a former chair of HERF.

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Practice Parameter Review Under MinnesotaCare

MinnesotaCare calls for the implementation of practice parameters, and an advisory committee and review panels have been formed to facilitate the process.

Greg Gifford, Ph.D.

The MinnesotaCare Act of 1992[1] calls for the adoption and implementation of practice parameters or guidelines to promote cost-effective health care in Minnesota. The following is a brief overview of the current status of parameter implementation under the law.

MinnesotaCare requires the commissioner of health to appoint a Practice Parameter Advisory Committee to assist the commissioner and the Minnesota Health Care Commission in the development and approval of practice parameters by the state. The Practice Parameter Advisory Committee has received guidance from the Institute of Medicine, the federal Agency for Health Care Policy and Research, the American Medical Association, and the Minnesota Medical Association. To assure that Minnesota and federal initiatives will complement each other, the committee has adopted the technical direction provided by the Institute of Medicine to the Agency for Health Care Policy and Research (AHCPR) on the development, implementation, and evaluation of clinical practice guidelines[2,3] (see related article, page 18). Use of practice parameters approved by the state will be encouraged but not required.

Practice Parameter Review and Approval

As required by law, the commissioner of health approves practice parameters after receiving advice and recommendations from the Practice Parameter Advisory Committee (PPAC), the Data Analysis Unit, and the Minnesota Health Care Commission.

The PPAC consists of seven physicians, three health plan representatives, one nurse, one chiropractor, two health services researchers, and one person from the medical technology industry. The committee's current role is to develop, recommend, and implement a process for review of practice parameters by the state, and to provide technical expertise to the commission and commissioner as needed. The law identifies certain criteria, or attributes, of practice parameters that should be used in their assessment and evaluation. For example, the statutory definition of practice parameters gives particular credibility to parameters supported by outcomes research, approved by the AHCPR, or adopted by certain national professional health care associations. In fact, the law exempts from rulemaking requirements practice parameters approved by the AHCPR or adopted by certain national professional health care associations.

The committee has determined that it will use a set of criteria or attributes in assessing and evaluating practice parameters in addition to the criteria required by law. The committee has adapted the Institute of Medicine's "Provisional Instrument for Assessing Clinical Practice Guidelines," which is based on a set of "desirable attributes" that the AHCPR uses in its development and evaluation of guidelines (see table, page 16).

Practice Parameter Review Process

The MinnesotaCare law clearly recognizes the importance of an organization of community experts to oversee the assessment of practice parameters approved by the PPAC. The committee's review process will include review panels that have expertise in each practice parameter condition area. The role of these expert panels will be to 1) review existing clinical practice parameters or guidelines that are national in scope and origin, i.e., from the AHCPR or selected national health care associations; 2) complete the Institute of Medicine's Provisional Instrument, as adapted by the PPAC; and 3) make recommendations to the PPAC regarding approval, including possible suggestions for additional documentation and/or minor modifications.

A summary of the expert review panels' assessment will be prepared and then discussed jointly between the

Table

Desirable attributes of clinical practice guidelines[*,3]

Attribute	Explanation
VALIDITY	Practice guidelines are valid if, when followed, they lead to the health and cost outcomes projected for them. A prospective assessment of validity will consider the substance and quality of the evidence cited, the means used to evaluate the evidence, and the relationship between the evidence and recommendations.
Strength of evidence	Practice guidelines should be accompanied by descriptions of the strength of the evidence and the expert judgment behind them.
Estimated outcomes	Practice guidelines should be accompanied by estimates of the health and cost outcomes expected from the interventions in question, compared with alternative practices. Assessments of relevant health outcomes will consider patient perceptions and preferences.
RELIABILITY/REPRODUCIBILITY	Practice guidelines are reproducible and reliable if 1) given the same evidence and methods for guideline development, another set of experts produces essentially the same statements, and 2) given the same clinical circumstances, the guidelines are interpreted and applied consistently by practitioners (or appropriate parties).
CLINICAL APPLICABILITY	Practice guidelines should be as inclusive of appropriately defined patient populations as evidence and expert judgment permit, and they should explicitly state the population(s) to which statements apply.
CLINICAL FLEXIBILITY	Practice guidelines should identify the specifically known or generally expected exceptions to their recommendations and discuss how patient preferences are to be identified and considered.
CLARITY	Practice guidelines must use unambiguous language, define terms precisely, and use logical and easy-to-follow modes of presentation.
MULTIDISCIPLINARY	Practice guidelines must be developed by a process that includes participation by representatives of key affected groups. Participation may include serving on panels that develop guidelines, providing evidence and viewpoints to the panels, and reviewing draft guidelines.
SCHEDULED REVIEW	Practice guidelines must include statements about when they should be reviewed to determine whether revisions are warranted, given new clinical evidence or professional consensus (or the lack of it).
DOCUMENTATION	The procedures followed in developing guidelines, the participants involved, the evidence used, the assumptions and rationales accepted, and the analytic methods employed must be meticulously documented and described.

*Developed by the Institute of Medicine (see reference 3) and approved by the Practice Parameter Advisory Committee, March 29, 1993.

Practice Parameter Advisory Committee and the review panels. The committee decided that, at least until it gains more experience, it will use results from the assessment to develop a group judgment or consensus within the committee before sending recommendations to the commissioner of health.

Practice Parameter Expert Review Panels

In preparation for assembling the practice parameter expert review panels in prenatal care, low back pain, and unstable angina, the committee determined that the panels would need to include experts in epidemiology and health services/clinical research methodology; specialist and generalist health care practitioners in the relevant discipline, representing both metro and nonmetro perspectives; and professionals with experience in developing practice guidelines.

The committee began recruiting panel members in November 1993. It placed an announcement of the vacancies in the *State Register* and asked for nominations from professional associations it considered relevant to the three condition areas. In addition, the Minnesota Department of Health issued a news release to various local media and government agencies announcing the vacancies. The PPAC tried to ensure the participation of all groups and disciplines (not exclusively physicians) that might be affected by the parameters.

The PPAC assembled a work group to review the 80 applications it received by the December 23, 1993, deadline. The work group attempted to ensure that the panels are sufficiently multidisciplinary and represent all relevant professional perspectives.

The PPAC finalized the work group's recommendations and forwarded them to the commissioner. After some deliberation, the commissioner accepted all committee recommendations and notified the selected applicants of their panel membership in March.

The panel composition is as follows. **Prenatal care:** two primary care physicians, two obstetrician-gynecologists, three nonphysician practitioners (two nurse midwives and one registered nurse), two epidemiologists, and one physician researcher. **Low back pain:** two primary care physicians, one orthopedic surgeon, a neurologist and a neurosurgeon, one physician specializing in occupational medicine, one physiatrist, two chiropractors, two registered nurses, one physical therapist, and two researchers. **Unstable angina:** two primary care physicians, two cardiologists, two cardiovascular-thoracic surgeons, two emergency medicine practitioners (one physician and one registered nurse), one other registered nurse, and two researchers. Some members of each panel have experience in clinical guidelines development, epidemiology, health services, or outcomes research. Each panel is co-chaired by two PPAC members. The panel members have been given orientation materials and began their initial orientation and training meetings in May. After orientation, the formal review of relevant practice parameters will begin. The panels' reviews are expected to take at most six months, with three-hour meetings held twice each month.

Implementation and Next Steps

Once practice parameters are approved by the commissioner, they will be published in the *State Register* and disseminated "to all practitioners in the state who diagnose or treat the (relevant) medical condition." In addition, given the necessary resources, practice parameters might be assessed for treating pneumonia and managing labor at term, two areas that the commissioner of health has approved for initial focus of the practice parameter initiative. However, the PPAC has not yet agreed to begin the review of parameters for these condition areas. MM

Greg Gifford is a research analyst with the Minnesota Department of Health, where he is working on implementing the health care quality research and clinical practice guideline/parameter initiatives of MinnesotaCare.

This article is extracted from a report to the Minnesota Health Care Commission by the PPAC called "Practice Parameters and MinnesotaCare" dated August 1993 and updated in April 1994. Although the changes to the original reflect decisions agreed to by the PPAC, the PPAC has not yet approved the updated report.

Members of the PPAC are Charles Field, M.D., chair; Amos Deinard, M.D.; Richard Dinter, M.D.; Jinnet Fowles, Ph.D.; Gwen Halaas, M.D.; Rona Hanson, R.N.; Gregory Hynan, D.C.; Robert Kane, M.D.; Barbara LeTourneau, M.D. (alternate); Raymond Lindeman, D.C.; Robert Meiches, M.D.; Gordon Mosser, M.D.; Royce Pipes; MaryAnn Stump, R.N.; and Richard Sturgeon, M.D.

REFERENCES

1. MinnesotaCare Act of 1992, Minn. Stat. Ch. 549 (H.F. No. 2800) Article 7.
2. Field MJ, Lohr KN, eds. Clinical practice guidelines: directions for a new program. Washington, D.C.: Institute of Medicine, National Academy Press, 1990.
3. Field MJ, Lohr KN, eds. Guidelines for clinical practice: from development to use. Washington, D.C.: Institute of Medicine, National Academy Press, 1992.

The Agency for Health Care Policy and Research

AHCPR develops and evaluates clinical guidelines and distributes them widely throughout the country to promote cost-effective, quality health care.

The Agency for Health Care Policy and Research is an agency of the Public Health Service within the U.S. Department of Health and Human Services with the goals of improving the quality and effectiveness of health care, broadening access to services, and reducing health care costs. To help achieve those goals, AHCPR facilitates development, publication, and widespread dissemination of clinical practice guidelines. The guidelines are developed by private-sector panels of physicians, nurses, other health care experts, and consumers, and by contract with nonprofit entities. Guidelines are based on research findings and expert opinion.

Guideline Development

AHCPR's Office of the Forum for Quality and Effectiveness in Health Care arranges for the development, periodic review, and updating of clinical practice guidelines that health care practitioners and educators can use in determining how specific conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed. Based on the guidelines produced, the forum oversees development of medical review criteria, standards of quality, and performance measures that assist health care providers to assess or review the provision of health care.

A committee from the Institute of Medicine (IOM) of the National Academy of Sciences assisted AHCPR in defining clinical practice guidelines, medical review criteria, standards of quality, and performance measures as follows:

Clinical practice guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.

Medical review criteria are systematically developed statements used to assess the appropriateness of specific health care decisions, services, and outcomes.

Standards of quality are authoritative statements of 1) minimum levels of acceptable performance or results, 2) excellent levels of performance or results, or 3) the range of acceptable performance or results.

Performance measures are methods or instruments to estimate or monitor the extent to which the actions of a health care provider conform to practice guidelines, medical review criteria, or standards of quality.

The committee of IOM developed eight attributes of good clinical practice guidelines—validity, reliability/reproducibility, clinical applicability, clinical flexibility, clarity, multidisciplinary process, scheduled review, and documentation (see table in related article, page 16).

Selection of topics

In selecting topics for new guidelines, AHCPR considers many factors, including:

- potential for reducing clinically significant and unexplained variations in services and procedures used in the prevention, diagnosis, treatment, management, or outcomes related to the clinical condition;
- number of individuals affected by the condition;
- adequacy of scientific evidence related to treatment of the condition;
- amenability of the condition to prevention;
- specific needs of the Medicare and Medicaid populations; and
- cost of the condition to all payers, including patients.

In 1993, AHCPR began publishing an annual notice in the *Federal Register* inviting comments on guideline topics under consideration and requesting suggestions for additional new topics.

Methodology

The purpose of AHCPR-supported clinical practice guidelines is to enhance the quality, appropriateness, and effectiveness of health care. This is accomplished by using the best available research and professional judgment. Under AHCPR's guideline development methodology, all scientific evidence must be considered, the consequences of different opinions must be weighed, and the scientific evidence and subjective judgments supporting the chosen options must be described explicitly. The methodology emphasizes the importance of a

comprehensive evaluation of empirical evidence of effectiveness, significant outcomes (including those important to patients), benefits, and harms. Explicit documentation of methods, rationales, and assumptions is required.

When scientific and empirical evidence is lacking on a particular aspect of the condition, professional judgment and group consensus are used. The lack of evidence and the use of expert opinion are recorded to document how decisions were made in developing the guideline. The identification of areas of insufficient evidence provides guidance to AHCPR's research agenda and to research programs of other agencies and organizations.

Both appointed panels and outside contractors developing guidelines use the same approach, which includes the following basic steps:

- clearly define the major questions regarding the clinical condition to be addressed;
- review and analyze the available scientific research for each question;
- assess clinical benefits and harms of each intervention;
- review estimates of important patient outcomes for each intervention being considered;
- review current and potential health care costs associated with the guideline. Where cost information is available and reliable, provide costs of alternative strategies for the prevention, diagnosis, treatment, and management of the condition;
- invite information and comments on guideline topics from professional and consumer organizations, researchers, manufacturers, and others by direct mail and by publication of a notice in the *Federal Register*. Conduct an open meeting to hear public comments on issues relevant to the clinical condition;
- prepare guideline draft based on the available empirical evidence and on professional judgment where empirical evidence is insufficient;
- submit draft guideline to peer review and to pilot review in actual use by clinicians and other experts;
- revise draft guideline based on analysis of comments and information received;
- prepare the guideline in several formats appropriate for use by practitioners, consumers, educators, researchers, and others.

AHCPR publishes and disseminates the guideline to the appropriate audiences and evaluates assimilation of the guideline into clinical practice. The guideline is revised periodically to reflect new scientific evidence or changing professional consensus.

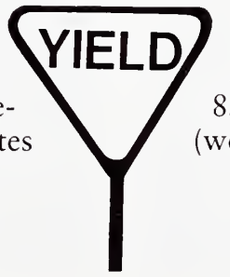
Guideline Evaluation

AHCPR evaluates the guidelines to identify the strengths and limitations of current methods, to refine methodological approaches, and to pursue research questions. Among the steps AHCPR takes to assess its guidelines are the following activities: conducts peer and pilot reviews of the draft guidelines in clinical settings before publication; conducts cost analysis of the recommended interventions and procedures; monitors awareness of guidelines by practitioners, consumers, and payers; examines how different modes of dissemination and implementation affect practitioner and patient behavior; evaluates specific guidelines in a variety of practice settings; and assesses the long-term effects of guidelines by examining evidence from large, longitudinal data sets containing information on utilization, outcomes, costs, and quality.

Guideline Dissemination

A clinical practice guideline is produced in several versions, each created to meet the particular needs of its audiences. The "Guideline Report" is a technical version that contains the clinical practice guideline and all supporting materials. The "Clinical Practice Guideline" contains specific recommendations and a summary of evidence and is intended for use by health care practitioners as a reference for clinical decision making. The "Quick Reference Guide for Clinicians" is an abbreviated version of the "Clinical Practice Guideline" for use as a desk reference. "A Patient's Guide" describes the condition and treatment options with benefits and risks in easy-to-understand terms and suggests questions to ask health care practitioners.

Guideline information will also be available online and in electronic formats through the National Library of Medicine, the National Technical Information Service, and some computer-based information systems of professional associations, nonprofit organizations, and commercial enterprises. AHCPR distributes guideline publications through its clearinghouse: AHCPR Publications Clearinghouse, PO Box 8547, Silver Spring, MD 20907; 800/358-9295 (weekdays, 9 a.m. to 5 p.m.). MM



The Minnesota Medical Association's Position on Practice Parameters

This MMA committee report provides a foundation for discussion of practice parameters as their use steadily increases in the quest for health system reform.

MMA Ad Hoc Committee on Quality Assessment and Data Utilization

The MMA recognizes that medical practice parameters are increasingly being touted, proposed, and implemented as promising strategies with the potential to enhance the quality and appropriate utilization of health care services, reduce the need for defensive medical practice, and improve decision making by providers, consumers, purchasers, policymakers, and others. The primary goal of practice parameters should be to maintain or enhance quality medical care through the use of continuous quality improvement (CQI) principles. They should primarily be used to improve the processes of health care overall, rather than solely focus on individual or atypical practice patterns. Practice parameters can also be used to optimize appropriate utilization of health care resources and reduce unnecessary tests and procedures by developing valid criteria for utilization management and payment decisions. Physicians should be provided with their individual data on practice patterns and outcomes to allow comparisons to be made with aggregate data acquired from other practitioners. Once the data are provided, physicians can determine the applicability and efficacy of a practice parameter and use the information for consideration in treatment options and for CQI.

Practice parameters should be based on accepted scientific principles, knowledge, and evidence-based outcomes research. In addition, they must be properly and thoroughly disseminated, tested, and validated; continually updated at appropriate intervals; and associated with a set of desirable outcomes and a mechanism for achieving those outcomes. To be meaningful, practice parameters must be used as an adjunct to a physician's knowledge, based on experience, biomedical theory, clinical research findings, and personal understanding of the patient, including the patient's history, examination findings, comorbidities, personal preferences, and choices.

Practice parameters should explicitly describe the range of acceptable practice, recognizing the complexity of medical decisions and the constant need for practitioners to maintain the ability to use individual clinical judgments. Therefore, practitioners must be allowed, when appropriate, to depart from a suggested practice parameter based on individual patients' needs, preferences, requests, and circumstances. After adequate dissemination of information specific to a practice parameter, practitioners should document adherence to, or the reason for departure from, an appropriately approved practice parameter.

Additionally, it must be determined whether the practice parameter is the "ideal" or "maximum" level of care, or whether it defines what would be considered "reasonable" or the "minimum" level. Conceivably, one practice parameter could describe the minimum level of acceptable care, while another could describe the optimal level. The MMA is concerned that practice parameters primarily developed to control costs and reduce what is surmised to be unnecessary care could result in the development of parameters that are skewed toward a minimum level of care and, therefore, could result in adverse outcomes for patients. Consequently, the MMA feels strongly that practice parameters should be developed primarily for the purpose of improving quality.

Because scientific data are scant regarding the relationship between parameters and improved health care outcomes, the MMA believes that practice parameters, collectively and individually, should be initially implemented on an experimental basis. However, in the event that practice parameters are mandated as part of programs adopted by states or other entities and organizations, a physician must be afforded legal protection for complying with a mandated practice parameter.

There must be appropriate liability protection to defend physicians who, without adequate protection, would be caught between the requirements of a practice parameter and the liability standards used by the court system.

Legal Implications of Practice Parameters

Defensive medicine occurs when a physician provides what may be deemed unnecessary services in order to reduce the likelihood of being sued for medical malpractice. Practice parameters have the potential to decrease defensive medicine by establishing the appropriate boundaries of acceptable medical practice, including the services and procedures recommended and deemed necessary. The 1992 MinnesotaCare legislation specifically established an absolute defense for a physician who complies with a practice parameter approved by the commissioner of health. The Legislature needs to re-evaluate this statute to ensure that adequate safeguards exist and that exceptions do not weaken or limit the liability protection for providers intended by the legislation.

Minnesota Statutes, Section 62J.34, Subdivision 3 (Medical Malpractice Cases) states:

(a) In an action against a provider for malpractice, error, mistake, or failure to cure, whether based in contract or tort, adherence to a practice parameter approved by the commissioner of health under subdivision 2 is an absolute defense against an allegation that the provider did not comply with accepted standards of practice in the community.

(b) Evidence of departure from a practice parameter is admissible only on the issue of whether the provider is entitled to an absolute defense under paragraph (a).

(c) Paragraphs (a) and (b) apply to claims arising on or after August 1, 1993, or 90 days after the date the commissioner approves the applicable practice parameter, whichever is later.

(d) Nothing in this section changes the standard or burden of proof in an action alleging a delay in diagnosis, a misdiagnosis, inappropriate application of a practice parameter, failure to obtain informed consent, battery or other intentional tort, or product liability.

The law states that adherence to practice parameters approved by the commissioner of health offers practitioners an absolute defense. It is the MMA's understanding that the legislation was intended to provide unconditional protection; however, it is unclear whether the absolute defense will indeed provide the liability protection if a case involving the use of practice parameters goes to trial. If a practice parameter is brought to a jury's attention in defense against an allegation of malpractice, then, in effect, the issue of the practice parameter is put "into play" and, accordingly, the practitioner must prove compliance with the practice parameter. The burden will be on the defense to demonstrate that the practitioner complied with the parameter. This will likely open the door for both the courts and plaintiff's attorney to interpret and reinterpret the recommendations described in the parameter. It will also provide an opportunity for plaintiff's counsel to assert noncompliance and challenge issues of fact based upon defense testimony regarding the parameter. A jury will be required to consider whether each detail of the treatment was precise, literal, and in complete compliance with each detail of the parameter in question. If a physician appropriately deviates from a parameter or portion of a parameter, a jury may believe that any deviation was negligent. Conversely, if a practitioner adheres to a parameter, it may raise a legal question about whether the practitioner should have deviated, albeit slightly, from the practice parameter if, in retrospect, the outcome was not satisfactory. The MMA has concern in regard to Minnesota Statutes, Section 62J.34, Subdivision 3, Paragraph (d), which essentially states that the standard or burden of proof is not changed in certain other situations, such as misdiagnoses and inappropriate application of a practice parameter, consequently removing the cause of action from the absolute defense statute and weakening the overall protection that is intended.

In addition, several significant issues should be seriously considered. The Legislature should address the following points and should distinguish between practice parameters as a quality of care issue as opposed to practice parameters as a legal standard of care, or the courts will undoubtedly develop case-law-setting standards.

"The primary goal of practice parameters should be to maintain or enhance quality medical care through the use of continuous quality improvement principles."

1. Practice parameters generated by the action of governments and voluntary professional entities may result in litigation irrespective of their incorporation into statutes affecting health policy, professional liability, and other health care legislation.

2. No conclusive data indicate that practice parameters decrease malpractice claims.

3. Practice parameters may not increase the defensibility of malpractice allegations and should not be extolled as doing so until conclusive evidence exists that malpractice allegations have decreased with the use of appropriately approved practice parameters.

4. Practice parameters should not become mandatory standards of care. In a case of alleged malpractice, a practice parameter is only one of many sources of evidence that may be introduced relative to what constitutes a legal "standard of care."

5. Although the medical community may regard practice parameters as "strategies" or "recommendations for care," the courts are increasingly adopting practice parameters as an expression of a "legal norm" or a "standard of care." This significant variance in nomenclature and interpretation could adversely affect practitioners who feel unable to deviate for fear of an allegation of nonadherence to what a court may hold as a legal norm, even if deviation was thought to be in the patient's best interest.

Based on the above information, the MMA position on practice parameters as legal standards of care is as follows:

1. Ideally, outcomes research should be the basis for practice parameters and should be used as a means of evaluating the most effective treatment option for most patients with a given condition. Practice parameters that are not supported by scientific research and controlled studies could be flawed. Therefore, until adequate research proves a parameter valid, reliable, predictable, efficacious, and usable, a practice parameter should not be used as a legal standard of care.

2. Because there is currently little practical, long-term experience with the use of parameters to show how they affect day-to-day practice and improve outcomes, practice parameters must be initially viewed as an experimental means of establishing acceptable boundaries of medical practice.

Practice Parameter Development

Several key attributes must be considered in the development of practice parameters. They are as follows:

• PRACTICE PARAMETERS SHOULD BE DEVELOPED BY OR IN CONJUNCTION WITH PHYSICIAN ORGANIZATIONS. Research has shown that physicians will incorporate practice parameters into day-to-day practice when they have been part of the development and endorsement process and when they are made aware of practice parameters that are based on scientifically sound, clinically germane information. Relevant physician organizations should also review, modify if appropriate, and endorse practice parameters prior to dissemination and implementation.

• RELIABLE METHODOLOGIES SHOULD BE USED TO INTEGRATE PRACTICE PARAMETERS WITH RELEVANT RESEARCH FINDINGS THAT LINK PRACTICE PARAMETERS WITH DESIRED HEALTH AND COST OUTCOMES. Practice parameters must be proven reliable by testing and evaluation. Appropriate development of practice parameters requires the synthesis of a broad array of medical information, including scientific studies, research findings, clinical experience, and expert opinion of medical specialists. Scientific and clinical evidence should always take precedence over expert opinion and consensus. Statements regarding the basis for and level of credibility should be noted and available for every practice parameter.

• PRACTICE PARAMETERS SHOULD BE AS COMPREHENSIVE AND SPECIFIC AS POSSIBLE, DEFINING THE POPULATION OF PATIENTS TO WHICH RECOMMENDATIONS APPLY. A practice parameter should denote the risks and benefits of various management strategies and indicate categories of relative appropriateness for management of a specific clinical situation, e.g., appropriate, equivocal, or inappropriate. In addition, a practice parameter should be detailed enough to be applicable to a specific condition, but must allow for unique patient circumstances.

• PRACTICE PARAMETERS SHOULD BE BASED ON CURRENT INFORMATION. It is essential that a practice parameter take into account all current knowledge of a condition or treatment. Particularly important is the incorporation of information on contemporary technology and the results of outcomes research. Also, it must be noted when developing a practice parameter that new technology is not available in all sectors of the health care industry. It must not be assumed that all providers will have access to specific technologies that may be suggested or recommended in a particular practice parameter, thereby preventing compliance.

• A PRACTICE PARAMETER MUST BE REVIEWED AT REGULAR, PRE-ESTABLISHED INTERVALS AND REVISED, IF WARRANTED. A system must be established to monitor the emergence of new information and advances in medical knowledge and technology that could alter an existing practice parameter. This would ensure that practice parameters are based on current information, scientific studies, proven technology, outcomes research, and changing professional consensus.

• PRACTICE PARAMETERS MUST BE WIDELY DISSEMINATED AND

PRACTITIONERS PROVIDED ADEQUATE TIME FOR IMPLEMENTATION. Effective methods of disseminating practice parameters must be identified and a viable system for publishing parameters established. To date, there is insufficient research indicating the most effective means of disseminating information about practice parameters. Physicians who are unaware of the existence of a practice parameter cannot be expected to consider or utilize it. Therefore, substantial research needs to occur on the issue of practice parameter dissemination before holding a physician accountable for using a specific practice parameter.

• PRACTICE PARAMETER DEVELOPMENT SHOULD NOT STIFLE INNOVATION IN TECHNOLOGY OR MEDICAL PRACTICE. It is imperative that practice parameters not inhibit innovation. The inherent danger that lies in practice parameter development is the tendency to conclude that prevailing care and subsequent practice parameters based on that care are the only correct methods of treating a given condition. This supposition may preclude the development of and authorization to apply new technology, processes of care, and pharmaceuticals that could improve medical care, thus sustaining the status quo rather than encouraging innovation that could lead to improved health care.

• PRACTICE PARAMETERS MUST BE NON-PROPRIETARY, AND THEIR DEVELOPMENT METHODOLOGY SHOULD BE AVAILABLE TO PRACTITIONERS. Therefore, if more than one practice parameter exists for a given condition, a practitioner must be free to follow the parameter that has been developed based on accepted scientific methodology, has been approved by the appropriate national medical specialty society, and is backed by scientific evidence. Currently, payers and other entities have developed proprietary practice parameters for specific conditions. Several parameters have been developed solely for cost-containment purposes. Integrated service networks (ISNs) and other health care entities will most likely continue to develop parameters unique to their organization, thereby requiring providers who may belong to more than one ISN or other provider group to be cognizant of every parameter that has been developed for a given condition. In addition, it must be noted that the majority of these practice parameters will not be sanctioned by the commissioner of health, thereby ruling out the absolute defense protection provided by statute. If physicians are required to comply with practice parameters developed by an individual ISN or other entity, the state must require standardized practice parameters. While the MMA supports the development and utilization of practice parameters, they must be tested and validated before being made mandatory.

Purposes of Practice Parameters

Practice parameters may be used for these purposes:

• to improve clinical decision making and quality of care through CQI studies;

• to educate practitioners and decrease indecision regarding the most efficacious treatment options;

• to educate and inform patients and assist decision making regarding treatment options;

• to guide the allocation of health care resources;

• to assess the effectiveness of new technology, pharmaceuticals, and treatments;

• to potentially reduce the risk of legal liability; and

• to develop criteria for payment or utilization decisions.

Practice Parameters for Use in CQI

Practice parameters can by used in continuous quality improvement for the following purposes:

• to identify problems in systems, processes, or outcomes by the recognition of patterns of care that do not produce desired results;

• to institute corrective actions and internally monitor to assure desired change is occurring;

• to improve planning, assessment, and procedural techniques based on statistics and science;

• to improve information used for patients' decision making;

• to standardize systems and processes that will reduce inappropriate variability; and

• to feed back evidence-based information to practitioners regarding differences in practice patterns. MM

Members of the Ad Hoc Committee on Quality Assessment and Data Utilization: Kenneth Dedeker, M.D., chair; Blanton Bessinger, M.D.; Paul Bowlin, M.D.; Tom Cathey, M.D.; Robert Cumming, M.D.; Daniel Dunn, M.D.; David Estrin, M.D.; Gary Fifield, M.D.; G. Richard Geier, M.D.; Paul Hamann, M.D.; James Knapp, M.D.; Bruce Norback, M.D.; Ron Rehmann, M.D.; Joseph Rigatuso, M.D.; Thomas Rose, M.D.; Alvin Schultz, M.D.; Robert Scott, M.D.; Paul Spilseth, M.D.; Ronald Villella, M.D.; L. Ashley Whitesell, M.D.; and Barbara Yawn, M.D. MMA Staff: Patricia C. Hanson, R.N., manager of quality, data, and peer review, and Theodore M. Thompson, Esq., MMA legislative counsel.

Peddling Drugs to Docs

By Ralph C. Heussner Jr.

Chapter I—Drug Promotion

Once upon a time, a doctor's decision to use a new drug was based solely on its scientific and clinical merits. The doctor would learn of the new Drug B from a journal article, detailman, medical education conference, or advertisement. Based on the information and comments from respected colleagues, the physician would choose Drug B over the old Drug A. And life would go on until Drug C came to market.

But in recent years, certain aspects of drug promotion have caused the public to wonder how and why a doctor chooses a particular drug. In fact, the promotional activities of the pharmaceutical industry have been studied by academics, scrutinized by legislators, debated before professional societies, investigated by the news media, and criticized by the White House.

In late 1990, for example, Sen. Edward Kennedy held highly publicized congressional hearings that criticized drug company promotional practices as unethical.

In 1992 *Consumer Reports* published a scathing two-part series on the relationship between the pharmaceutical industry and medicine that concluded "commercial interests have infected medicine in numerous ways."

More recently, President Clinton has charged that the pharmaceutical industry is partly to blame for escalating health care costs.

All in all, public relations have not been good for the pharmaceutical industry. Does the industry deserve the bad rap? And what really sells a drug today? *Minnesota Medicine* takes a look.

Advertising and Education

Most of the criticism of the pharmaceutical industry in recent years has been directed at drug promotion, especially advertising and industry support of scientific programs.*

Critics harp on the fact that 20 to 22 cents of every dollar earned in the pharmaceutical industry goes to promotion, while only about 15 cents is spent on research and development. The critics include the crusading doctor-lawyer commissioner of the U.S. Food and Drug Administration, David Kessler.

Soon after taking over the FDA in 1991, Kessler pledged in a much quoted *New England Journal of Medicine* editorial: "The FDA is determined to ensure that the promotional activities of pharmaceutical firms are identifiable as such and that they conform to the laws."

It wasn't always that way. One of Kessler's first acts after assuming his position was to empower the FDA's Division of Drug Marketing, Advertising and Communications with more staff and authority. Previously, according to Kessler, "We wrote letters, we wrote letters, and we wrote more letters."

Now, as Kessler promised, the agency has been paying closer attention to the promotional messages of the pharmaceutical industry. According to an FDA spokesperson: "We consider all information given out by drug companies about their products to fall under our jurisdiction. In the broadest sense of the word, it's all promotion."

Advertising, in particular, is under the FDA's watchful eye. New drug labeling regulations require drug firms to substantiate through controlled studies any comparative claims about how a drug differs from a competitive product. In addition, the FDA is cracking down on companies that promote unapproved uses of drugs.

The FDA has also censored press releases, newsletters, journal supplements, and other communications issued by pharmaceutical firms that include remarks taken out of context or that omit references to side effects.

The tighter FDA restrictions have followed years of congressional inquiries, media investigations, and editorial debates in academic journals. Douglas Waud, M.D., sparked one such debate with the following comments, published in the July 30, 1992, *New England Journal of Medicine*: "I can see no role whatsoever for drug advertising. I believe that practically all the problems associated with physician interactions with the drug industry would vanish were advertising out of the picture."

Waud, from the University of Massachusetts Medical School, also blasted physicians for accepting gifts from the industry and for seeking and accepting pharmaceutical subsidies for scientific meetings and continuing medical education conferences. (Waud's editorial triggered more than a dozen letters from physicians arguing the ethical dilemmas of pharmaceutical promotion.)

Under siege, pharmaceutical industry leaders are fighting back. Robert A. Ingram, president of Glaxo, Inc., wrote in the October 1993 issue of the journal *Medical Marketing & Media*, "We have all heard the argument, repeated by President Clinton and others down the line, that the industry spends more on adver-

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* Most recently, the Department of Health and Human Services Office of Inspector General has indicated that it will be issuing a "fraud alert" relating to pharmaceutical marketing. Fraud alerts describe practices that do not qualify for safe harbor protection under the Medicare and Medicaid fraud and abuse laws. The Office of Inspector General has indicated that the alert may be published in July.

"No doctor is going to change his practice based on a couple pieces of pizza. The reps know that. The doctors know that."

—PHARMACEUTICAL REP

tising than it does on R&D. This is followed by the implication that promotion is somehow a sleazy activity, just one step removed from carnival barkers and snake-oil salesmen. ... Never mind that we're producing increasingly complex products that must be thoroughly explained to the health care professional. Never mind that most physicians welcome our representatives. Never mind that history has shown again and again that no matter how innovative a medical advance may be, health professionals do not adopt it spontaneously. Instead, they must develop a comfort factor, gain experience with it. Then—depending on the product—one day it crosses that magic threshold into standard therapy, and the medical world wonders how it ever got along without it."

The Pharmaceutical Manufacturers Association has also launched a counteroffensive, placing full-page ads in national magazines. One such ad, in the April 25 *Newsweek*, reads, "Drug companies are now testing 86 new medicines for heart disease and stroke. With over 90 percent of drug discoveries coming from pharmaceutical company research, these efforts hold the best hope for fighting heart disease and dramatically reducing health costs." The ad invites readers to call or write the association "to learn more about our research on new medicines for heart disease and other illnesses."

Philip Huston, editorial consultant to *Medical Marketing & Media*, may have summarized the prevailing attitude of the pharmaceutical industry when he wrote last year, "We've heard more than we want to about what the FDA, the AMA, and various congressmen think of the efforts of pharmaceutical companies to educate physicians about their products."

Direct-to-consumer advertising

Over the last decade, pharmaceutical promotion has zeroed in on a new target—the public; increasingly, pharmaceutical ads are directed at patients, not doctors. Since the FDA lifted its moratorium on "direct-to-consumer" advertising for prescription drugs in 1985, the practice has grown steadily. Drugs for treating allergies, hair loss, and tobacco addiction are among those promoted in such popular publications as *People* and *USA Today*.

Under FDA rules, the ads must observe "fair balance" and describe the risks and benefits of the drug objectively. If an ad describes a drug's benefits, it must also list its side effects and limitations.

Supporters of consumer-focused advertising say direct-to-consumer ads educate the public about health problems and their solutions. Critics, including several major physician groups (the American Medical Association, the American College of Physicians, and the American Academy of Family Physicians among them), claim they're misleading and interfere with the doctor-patient relationship while creating inappropriate patient demands and expectations.

Advertising in national media is significantly more expensive than advertising in scientific journals, but the investment appears to be paying off. In 1989, only 45 percent of 5,000 physicians polled in an industry-backed survey said a patient had requested a product by name. By 1992, the number had almost doubled, to 88 percent.

Twelve years ago, Jay Cohn, M.D., head of the

Pharmaceutical Gift Giving

Probably no area of pharmaceutical/physician interaction has generated as much controversy as gift giving. (See related article, page 41.) Acknowledging that "some gifts that reflect customary practices of industry may not be consistent with the principles of medical ethics," the American Medical Association issued in December 1990 the following guidelines, which have been incorporated into the AMA's code of ethics.

1. Any gifts accepted by physicians individually should primarily entail a benefit to patients and should not be of substantial value. Accordingly, textbooks, modest meals, and other gifts are appropriate if they serve a genuine educational function. Cash payments should not be accepted.

2. Individual gifts of minimal value are permissible as long as the gifts are related to the physician's work, e.g., pens and notepads.

3. Subsidies to underwrite the costs of continuing medical education conferences or professional meetings can contribute to the improvement of patient care

Cardiovascular Division at the University of Minnesota, wrote a lead editorial in the journal *Circulation* titled "Science and Advertising" in which he called for a greater separation of science and advertising. He noted that a form of advertising "has been creeping into the more pristine areas of our profession—journal articles, scientific presentations, grant proposals, and lectures." In defense of industry promotion, he wrote, "Is advertising always bad, to be guarded against, to be shunned? Indeed not. When the cause is honorable, advertising may be appropriate and necessary." However, he lamented that the "distinction between science and advertising is becoming more blurred."Over the next decade, that line would become fuzzier still.

Medical education support

Undeniably, the relationship between the drug industry and the medical profession is mutually beneficial. Many medical education programs, from grand rounds at individual hospitals to national medical conferences drawing thousands of practitioners, depend on financial support from pharmaceutical companies. And, historically, the industry has poured much needed advertising dollars into medical journals and supplements.

Indeed, pharmaceutical support of medical education is a mammoth and expensive enterprise. In 1988, a congressional study found that 16 companies had funded 34,688 symposiums at a cost exceeding $85.9 million. In comparison, in 1974, the same companies had subsidized 7,519 symposiums at a cost of $6.5 million in adjusted 1988 dollars.

In a 1992 survey of the nearly 2,000 Intrastate Accredited CME Providers, approximately 63 percent of the 800 respondents said they received up to half their CME support from pharmaceutical sources. If support were discontinued, 74 percent said it would create problems ranging from a minor adjustment to serious impact, although only 1 percent said CME would be discontinued if industry support were withdrawn.

In the last few years, medical education planners have changed the way they work with the pharmaceutical industry. The changes are in response to new guidelines from various accrediting associations, the American Medical Association, and the FDA. Hospitality events have been drastically reduced or eliminated. Ex-

and, therefore, are permissible. Since the giving of a subsidy directly to a physician by a company's sales representative may create a relationship that could influence the use of the company's products, any subsidy should be accepted by the conference's sponsor, who, in turn, can use the money to reduce the conference's registration fee. Payments to defray the costs of a conference should not be accepted directly from the company by the physicians attending the conference.

4. Subsidies from industry should not be accepted to pay for the costs of travel, lodging, or other personal expenses of physicians attending conferences or meetings, nor should subsidies be accepted to compensate for the physicians' time. Subsidies for hospitality should not be accepted outside of modest meals or social events held as part of a conference or meeting. It is appropriate for faculty at conferences or meetings to accept reasonable honoraria and to accept reimbursement for reasonable travel, lodging, and meal expenses. It is also appropriate for consultants who provide genuine services to receive reasonable compensation and to accept reimbursement for reasonable travel, lodging, and meal expenses. Token consulting or advisory arrangements cannot be used to justify compensating physicians for their time or their travel, lodging, and other out-of-pocket expenses.

5. Scholarship or other special funds to permit medical students, residents, and fellows to attend carefully selected educational conferences may be permissible as long as the selection of students, residents, or fellows who will receive the funds is made by the academic or training institution.

6. No gifts should be accepted if there are strings attached. For example, physicians should not accept gifts if they are given in relation to the physician's prescribing practices. In addition, when companies underwrite medical conferences or lectures other than their own, responsibility for and control over the selection of content, faculty, educational methods, and materials should belong to the organizers of the conferences or lectures.

hibits have been moved to off-site locations. And program content is being more closely monitored.

The FDA has traditionally recognized what has been termed a "safe harbor" for educational activities supported by the pharmaceutical industry, provided the programs are free of promotional influences. The safe harbor allows accredited CME providers to present information on the use of drugs without having to meet FDA regulations regarding labeling and advertising. However, drawing the distinction between education and promotion has proven difficult. The agency has been struggling for several years to develop practical guidelines that would distinguish the two.

The FDA in November 1992 issued a revised draft policy on educational activities that is designed to more clearly define the safe harbor for scientific and educational activities. An original draft published in 1991 underwent major revision after an outcry from industry and academics charging interference with free speech and academic freedom.

Under the revised draft, which addresses supporting companies' influence over CME program contents, CME activities must be non-promotional and characterized by "objectivity, balance, and scientific rigor." They must include a balanced discussion of the supporting company's product and of treatment alternatives, disclose data limitations, and identify unapproved uses. Live presentations must be followed by opportunities for questions and debate. In addition, ancillary promotional activities are prohibited, and exhibits must be in a separate room and away from an obligate pathway to the program.

Although the policy is still in draft form, it is widely followed and forms the basis for FDA enforcement. Currently, there is no clear consensus on the policy's impact.

Director of the University of Minnesota's CME program, Bart Galle, Ph.D., says the new guidelines have created "more paperwork than anything else, because we've always followed the same standards for objectivity and independence."

The industry itself is feeling the impact, argues Dan Foss, a medical education liaison with Upjohn. "With more regulation, some companies are going to pull the plug. Some already have."

But Stephen Goldfinger, M.D., of Harvard Medical School doubts the drug companies will make a radical retreat, or even a modest pullback. "For better or worse, the burgeoning support by the pharmaceutical industry of the education of physicians is here to stay. To fight it is to tilt at windmills. But it is not unreasonable to examine the various forms such support may take and to set our ethical antennae high enough to make some rudimentary distinctions."

In addition to underwriting major medical meetings, the drug industry also provides local support for teaching conferences in hospitals, a practice that drew sharp criticism from former University of Minnesota bioethicist Arthur Caplan, Ph.D.

In an October 1989 column in the *St. Paul Pioneer Press* titled, "Can Pizza Buy a Doctor's Loyalty?" Caplan questioned drug companies' long-standing practice of providing free lunches for medical school residents at teaching conferences. He concluded: "[E]ven if a doctor can be bought for the price of a free lunch, there is still no excuse for allowing pharmaceutical companies to ply their wares in educational settings. Doctors remind us constantly that theirs is a profession—not a business. But when business is allowed to go on in the back of the classroom, that is unprofessional."

At least one pharmaceutical rep is still fuming over the column. "First of all, we're not caterers. But more important, no doctor is going to change his practice based on a couple pieces of pizza. The reps know that. The doctors know that. And Caplan knows that. But what infuriated me the most was that a university department had just approached our company to help sponsor a medical conference."

Chapter II—Drug Promoters

A sign at the receptionist desk of a mid-size medical practice in Minneapolis reads: "All pharmaceutical representatives and other vendors please register in the business office."

The pharmaceutical company reps, commonly referred to as "detailmen," reportedly don't like the sign because it minimizes their role as educators and active participants in the health care delivery system. "The sign puts me on the same plane as the guy who is refilling the pop machine," complains one local drug rep.

For more than half a century, pharmaceutical reps have been knocking on doctors' doors and dispensing information about new drugs and other medical products. The first reported use of the term "detailman" appears in the 1928 proceedings of the 17th annual meeting of the American Drug Manufacturers Association as follows: "With the detailman, we tell our message through the human ambassador."

The pharmaceutical industry employs one sales representative for every 15 physicians in the United States. In England, the ratio is about 1-to-8. The industry spends more on reps than on the actual raw materials for its products. It costs an estimated $125,000 a year to support an individual rep. Apparently, it's money well-spent.

In the early 1970s, an AMA-sponsored survey of more than 98,000 physicians found that detailmen were the first source of information about new drugs from commercial sources. More recent studies have affirmed that drug reps continue to be an important reservoir of information, especially regarding the cost of drugs and tips on patient management.

Contacts with drug reps also affect the prescribing behavior of physicians, according to both pharmaceutical surveys and scientific studies. A pharmaceutical marketing journal calls reps "the best and most efficient means of convincing practicing physicians to prescribe certain medications."

Studies of docs and drug reps

Minnesota physicians have participated in two extensive studies of their interactions with pharmaceutical sales representatives. In 1987-88, internal medicine physicians (including both faculty and residents) at teaching hospitals in Minneapolis, St. Paul, and Milwaukee were surveyed regarding their contacts with drug reps and

about behavior that might be related to these contacts. Significantly, 25 percent of faculty and 32 percent of residents said they had changed their practice at least once in the preceding year based on a discussion with a rep; and 20 percent of faculty and 4 percent of residents said they had recommended additions to the hospital formulary at least once in the past year based on a rep's suggestions.

In conclusion, the researchers suggested that contact with pharmaceutical representatives is "associated with a change in physicians' prescribing habits" and warned: "Medical educators should ensure that students and faculty know how to critically evaluate new information, especially as it appears in pharmaceutical studies and marketing literature."

Physicians at the same hospitals, which included the University of Minnesota, Hennepin County Medical Center, and St. Paul-Ramsey Medical Center, were also surveyed to determine physician perceptions and attitudes toward the reps themselves. Among the key findings:

- Residents and faculty both had somewhat negative attitudes toward the educational value of detailing;
- Residents were more likely than faculty to perceive contacts with sales reps as potentially influencing their decision making;

• Sixty-seven percent of faculty and 77 percent of residents indicated that physicians could be compromised by accepting gifts; and

• A majority of both house staff and faculty favored eliminating presentations by pharmaceutical representatives at their hospitals.

The physician's point of view

The negative response is not unusual; some physicians say they will not even meet with a pharmaceutical rep. Others say that their day-to-day interactions with reps are usually cordial but sometimes strained.

Renner Anderson, M.D., a pediatrician and research director at Park Nicollet Medical Center, admits he's uncomfortable when approached by drug reps.

"To be honest, I feel nervous when I'm dealing with a representative," Anderson says. "I'm always busy, and I'm usually skeptical of the information I'm receiving. I will take and review their literature, but I'm also aware that it is biased." Anderson says he first checks to see who sponsored the work and where it was published. If the article was published in an obscure journal, he doesn't read it.

"I've learned that you have to look at the articles closely because there are times when promotional materials look a lot like a medical journal—the type is the same, the format is identical. I just recently received such an article on the cost-effectiveness of the chickenpox vaccine. The other materials—the colored brochures with the fancy diagrams—often don't tell you what you need to know.

"However, the pharmaceutical rep can be helpful in giving you information that might not be found in a journal," he adds. "For example, I prescribe Augmentin quite frequently. But it causes significant diarrhea and, therefore, needs to be taken with food. I learned from a pharmaceutical rep that the patient doesn't need to have a whole meal, but a cracker would do fine. I appreciated that little fact."

St. Paul internist James Finnell says, "For the most part, I've had a positive experience with detailmen. I try to find time, either at the hospital or clinic, if the representative has something I'm interested in."

He's most interested in meeting with reps to obtain sample medications and patient literature. "If someone doesn't have the means to purchase the medication, or if they are very ill and need it right away, having samples available on the shelf can be very helpful," says Finnell. "I've also found some of the patient education material to be extremely useful and well-done."

Volunteering one peeve about drug promotion, Finnell says, "I wish they would stop sending me silly things in the mail. I've received a gavel, beach towels, and pens. No doctor is going to base a clinical decision on a trinket."

The drug rep's perspective

While the medical profession continues to view pharmaceutical representatives as vendors and as "detailmen," the reps see themselves as educators, facilitators, and problem-solvers.

"First, I don't like the term 'detailmen' because there is a growing number of women in the field," says Kate Wenzel, a regional product specialist for Astra Pharmaceuticals who covers Minnesota and the Upper Midwest. "And, second, I think it's an outmoded term that doesn't really convey what we do."

Kevin Rieber, who travels a four-state area for MedImmune, says drug reps must be educators. "You might be asked to do literature searches or to provide more information about a drug's toxicology and clinical trials."

Upjohn's Dan Foss describes his job as helping people solve problems. "Our approach is to focus on 'disease concept selling.' We talk about the patient's problem and, hopefully, our product will come into play as part of the solution to the problem."

Drug reps acknowledge that some physicians react coolly when they call, although other doctors may go out of their way to be accommodating after a relationship has been established.

"You can't overstay your welcome. Otherwise, you won't be invited back," says Wenzel. "I have learned to take a step-wise approach in developing the relationship. You may introduce the product during a brief first visit, then the next time try to give more information about patient management."

Rieber agrees that breaking through resistance can be the toughest part of the job. "Doctors are receptive if you can provide something of value. If you can't prove that you have something unique, then you are imposing on their time," he says. "There is one clinic in Wisconsin that absolutely will not see any rep. And it shows. I don't think there's been a change in their clinic formulary in 10 years."

Generally, say the reps, younger physicians seem more receptive than their older colleagues. "[Younger physicians] realize that there is no way they can keep up-to-date with all the changes taking place in medicinal chemistry and everything else in science," explains one representative, who could not be identified because of

company policy on press relations. "Whereas I only need to be intimately familiar with a handful of new drugs, the physician must have a general knowledge of hundreds. They simply cannot keep abreast of everything that's happening in the industry today."

Physicians sometimes don't appreciate just how well pharmaceutical representatives know their products, argue the reps, most of whom have backgrounds in pharmacy, marketing, or the biological sciences. Doctors may not know how much time goes into drug reps' education and preparation before a product is brought to market, says Rieber. Johnson and Johnson, for example, requires sales staff in the company's surgical products division to learn firsthand how the devices are used by working on cadavers. During Rieber's tenure with the company, he and his colleagues became so proficient that "We would train surgeons with some laparoscopic tools during three-day courses."

An endangered species?

The pharmaceutical rep may be an endangered species. According to Jay Cohn of the university, "The role of the sales representative as educator of physicians about new drugs is just about gone. Maybe they can still fulfill that role [for physicians] in private practice, but as far as academic medicine, I see the role of the sales representative decreasing. Sales reps in the future may need to be better educated about the field."

In fact, Cohn has established a preceptorship program for pharmaceutical representatives interested in cardiovascular disease. Reps undergo as much as three to four days of intensive education at the university.

But a more ominous change appears on the horizon. "Clearly, in the future, a physician's decision to prescribe a drug will be determined by other factors, such as managed care and ISNs, and less and less on the individual preference," says Cohn. "For example, if there are 10 ACE inhibitors on the market, all of equal efficacy, a pharmacy is not going to carry all 10. They may carry only two or three to choose from."

With its usual business acumen, the pharmaceutical industry is already reacting to the changing health care environment; its sales reps are spending more time detailing with pharmacists and members of hospital formulary committees—and less time knocking on doctors' doors. Whether or not that's good medicine remains to be seen. MM

Ralph Heussner recently became public relations manager for Gillette Children's Hospital in St. Paul after 14 years as a medical writer and administrator at the University of Minnesota.

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HARRIS

(continued from page 7)

the university's doctors and nurses began by defining the things they could count—length of stays, complications, readmission to the hospital within 30 days, etc. "Traditionally, studies had concentrated on the effectiveness of care, not on efficiency," Harris explains. "We had not compared the cost-effectiveness of different techniques that got the same results. But that's what much of the current changes in health care are about—measuring the outcomes and the cost of different processes of care. To improve the outcome, you must improve the process. Professionals began to ask each other: 'Why do you do it that way? What improvement do you see in outcomes?' The staff found that many differences in style were just based on differences in training."

To provide more consistent care, the hospital established guidelines that help staff decide when to select one technique or treatment over another. Then it set up pathways for the day-to-day delivery of care. Pathways allow for some variation because what works best is still being determined and because the hospital doesn't want to stifle creativity. Measuring the outcomes ("Did you achieve the care goal? What is the patient's functional status? Is the patient satisfied?") is the final part of the equation.

"Outcomes, pathways, and guidelines form an important feedback loop," says Harris. "They are our tools for making sure cost containment and quality don't collide. By measuring the results of the care provided and comparing them against our guidelines and pathways, we are ultimately able to manage outcomes, which is the real goal."

UMHC is concentrating on developing pathways for high-volume and high-cost procedures, for procedures with many complications, and for those with no consensus on the proper treatment. Approximately 37 pathways are in various stages of development and implementation, including, hip replacements, treatment of newborns weighing less than 5,000 grams, liver transplants, and cholecystectomies.

With such a large number of pathways, accurately measuring outcomes is difficult, according to Harris. "If you really want to get good information, then there's a certain rigor in designing how you collect data all along the patient care process, how you analyze it, and how you use it."

> "Guidelines are tools for making sure cost containment and quality don't collide."
>
> *–Jean Harris, M.D.*

To enhance the value of the information it is obtaining, UMHC is combining its data with other organizations for specific disease categories. For example, the university is cooperating with the Colon-Rectal Associates physician group, Health East, North Memorial, and the Fairview system on separate studies of rectal cancer and hemorrhoids.

Harris says the impact of the university's changes in patient care can already be seen. For example, by standardizing the processes of care, liver transplant patients' hospital stays decreased by 10 days, and kidney transplant patients' by three days—with no loss in the quality of care. Doctors review internal reports on quality assurance and quality improvement performance, and they now challenge one another. A doctor whose treatments cost more than another's—with the same care results—will hear about it and will want to change. Medical residents also feel the impact. "Some residents were ordering multiple MRIs on the same patient," Harris says. "With the guidelines and pathways, they can't order redundant tests anymore. It's more appropriate resource utilization."

To formally measure the results of its pathways and guidelines, the hospital and the University of Minnesota Clinical Associates (a private practice group of university faculty physicians) have established an institute for outcomes research in the university's School of Public Health.

The hospital is striving to be more customer-focused. "We're actively and aggressively measuring patients' satisfaction with the outcomes of their care and the quality of their lives after their stay here," says Harris. "We're asking patients questions like: 'Is your daily life better? How was your hospital experience? Were things explained adequately? Did you receive counseling on aftercare?' "

At a time when the health care field is in great flux, Harris is confident that Minnesota and UMHC will successfully adapt to the changes ahead. She's doing her part by putting into practice some wisdom from Sir Francis Bacon that she quotes in her speeches and presentations: "If we are to achieve results never before accomplished, we must expect to employ methods never before attempted." MM

James Bohen is a free-lance writer living in St. Paul.

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The Monitor

News For Minnesota Physicians

Announcements

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Call Now for a Summer Health Care Intern

If you would like to have a high school student or post-secondary school student work as an intern in your clinic or hospital during the summer of 1994, sign up now. The MMA will soon submit a list of clinics interested in participating in the Summer Intern Program.

The 1994 Legislature expanded the Summer Intern Program to include students who have completed high school and plan to complete a two-year or four-year degree program. The Summer Intern Program exposes students to a career in medicine by giving them hands-on experience in a hospital or clinic during the summer.

The hospital or clinic must agree to provide a six- to 12-week position that allows formal exposure to the health care profession and some patient contact, and must pay half the cost of the student's wages of $5 to $6 per hour. The student's school district will be awarded a state grant to pay the other half of the wages.

If your clinic or hospital is interested in participating in the Summer Intern Program, call Kristen Gloege at the MMA, 612/378-1875 or 800/999-1875. For more information about the program, contact Naomi Bowman at the Minnesota Hospital Association, 612/331-5571.

Governor Signs MinnesotaCare Bill

Gov. Arne Carlson signed the 1994 MinnesotaCare Act into law May 10, 1994. While the bill was awaiting the governor's action, MMA President C. Randall Nelms, M.D., wrote on behalf of the MMA urging the governor to sign it. "This legislation continues the state's commitment to reforming our health care system in order to control health care spending and ensure universal coverage for all Minnesotans," he wrote. "While there are aspects of the legislation that cause us concern, the MMA believes the positive components of the bill far outweigh these concerns." He commended the commitment to achieving universal coverage, the creation of community integrated service networks, and the ban on exclusive contracts.

Carlson said that if enactment of universal coverage requires significant new funding, he would call for a voter referendum.

Governor Uses Veto Power

The governor line-item vetoed an attempt to switch back into the Health Care Access Fund some of the provider tax money that was moved into the General Fund last year. In 1993, the Department of Human Services predicted that droves of people would apply for MinnesotaCare and then find they really belonged on Medical Assistance (MA). Therefore, legislators earmarked $38 million of the money raised by the 2 percent tax to go into the General Fund to pay for the expected onslaught of new MA recipients. But this year DHS reported the great influx of new MA recipients never occurred and such a large transfer wasn't needed. So this year's MinnesotaCare Act called for a transfer of more than $20 million back to the Health Care Access Fund where it belongs.

MMA Protests Use of Provider Tax to Balance Budget

The governor's veto means that money raised by the 2 percent tax will be used for purposes not remotely related to health care. The MMA wrote to Carlson protesting the use of the provider tax to balance the budget. His veto will increase the MinnesotaCare budget deficit and could make it impossible for the state to enroll more people into the program next year. The Minneapolis-based *Star Tribune* reports that Rep. Lee Greenfield, DFL-Minneapolis, accused Carlson of "breaking faith" with health care providers because he had promised the tax money would be used only for health care.

Legislators have said they plan to enact a stable broad-based funding source for MinnesotaCare next year. But now a higher tax increase will be needed because some of the health care money is being siphoned away for other purposes.

The governor also line-item vetoed an appropriation to the attorney general that would have funded state efforts to explore a possible lawsuit against the federal government challenging Minnesota's unfair Medicare reimbursement level. The MMA supported the Medicare challenge provision.

Viewpoint

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Gail L. Gamble, M.D.
Chair, MMA Board of Trustees

MMA Has Successes During 1994 Legislative Session

During the 1994 legislative session, the MMA achieved major goals and laid the groundwork for continuing debate next year.

A firm commitment to universal health care coverage was one of the MMA's highest priorities. In editorials, media interviews, and conversations with state officials and legislators, we urged lawmakers to require every Minnesotan to have health insurance and to institute insurance reforms that would make premiums more affordable. We said reform would only work in a system that requires everyone to be insured for basic health care benefits. At the beginning of the session, the Minnesota Health Department draft of the MinnesotaCare bill did not include insurance reforms or a universal coverage mandate, but we pushed hard for their inclusion and they were included in the final legislation.

We made progress toward a repeal of the 2 percent provider tax and enactment of a broad-based funding source for universal coverage. Clearly, the state will need to subsidize low-income families who cannot afford to purchase health insurance. In the past when we have talked about funding, we have encountered a brick wall because of the governor's veto threat. But this session, bills to replace the provider tax made it through the House and Senate committees, and a bill to use state reserve money to help fund the existing MinnesotaCare program passed and went to the governor, who unfortunately vetoed it. We've laid the groundwork to tackle funding again next year.

The slower ISN/RAPO timetable is another important accomplishment. We felt that the implementation schedule in the 1992 MinnesotaCare bill moved too quickly to allow an orderly transition to the new system. It would have required physicians to decide whether to be in an ISN or in RAPO before they had enough information to make an informed decision. The more realistic 1994 timetable requires all the rules for ISNs and RAPO, including the RAPO fee schedule, to be complete by July 1, 1996. This will allow a year for transition to full implementation in 1997.

One of our main goals was to make sure the MinnesotaCare bill would allow small community networks to form, especially in rural Minnesota. We stated that health system reform should encourage creative responses to the needs of the local community and should allow small players to compete with large health plans. In response, a new concept was developed—community integrated service networks (CISNs) that will have a two-year head start before ISNs form and three years to phase in their solvency requirements. We successfully urged legislators to make CISNs a permanent part of the health care system rather than sunsetting them in 1997 as originally planned.

In a major accomplishment, the MMA convinced legislators to ban exclusive contracts. The MMA successfully argued that protecting physicians from pressure to sign exclusive contracts would preserve freedom of choice for both patients and providers.

In spite of its importance and complexity, the MinnesotaCare legislation wasn't our only concern. The MMA tracked more than 30 health care bills this session. We gained protections for physicians' due process rights in the bill creating a diversion program for health care providers with mental or physical problems. In our continuing campaign against violence, we supported stronger crime penalties and education initiatives in the anti-crime bill. We supported legislation that would reduce tobacco-caused diseases. The ban on smoking in the common areas of apartment buildings was signed into law. A proposal to provide funds to educate the public about the dangers of secondhand smoke passed as part of the human services funding bill, but this bill was vetoed.

We can be proud of our achievements this session. One reason for success was the MMA's renewed focus on issues that directly improve patient care. As a result, we've won a new measure of respect from lawmakers and have been able to work more effectively with them to improve legislation affecting health care.

Another reason for success is the hard work of MMA leaders, members, and staff. I would like to thank the MMA leaders who devoted hours of their time advocating MMA policies and the MMA lobbyists who worked round the clock in the final days of session. I especially would like to thank all of you who testified before a committee, wrote letters, or called your legislators. Your support makes a tremendous difference. • • • • •

Summary of the 1994 MinnesotaCare Act

The 1994 MinnesotaCare Act slows the pace of health system reform by three years, setting July 1, 1997, as the target date for full implementation of integrated service networks (ISNs) and the regulated all-payer option (RAPO). The MMA told legislators that it would be hard for physicians to make crucial decisions about ISNs and RAPO before the concepts were fully developed. The new timetable will permit a smoother transition. It also allows lawmakers to put off decisions on the most controversial issues until the 1994 elections are behind them. Next session will be a crucial one for the MMA. Still to be decided are the basic benefits set, the ISN solvency requirements, the RAPO fee schedule, and the thorny dilemma of how to pay for universal coverage.

Universal Coverage

The act commits the state to achieving universal health care coverage by July 1, 1997. On that date, the following insurance reforms will be in place:

- Mandatory coverage. Every Minnesota resident will be required to have health insurance.
- Guaranteed issuance. Health plans will not be able to deny coverage.
- No underwriting restrictions. Premiums may not be based on health status or risk.
- No pre-existing exclusions. Insurance companies will not be able to impose pre-existing condition limitations and exclusions.
- Community rating. Premiums for a health insurance plan will be the same for everyone.
- Full portability. Everyone will be able to move insurance from public programs to private health plans and between insurance companies without restrictions or exclusions.

Missing from the bill is a decision on how the state will pay for universal coverage. The law does, however, direct the Minnesota Health Care Commission to submit recommendations for a long-range funding plan for all state programs to the Legislature by January 1995. The study must include recommendations for a broad-based tax and must consider a payroll tax or income tax. At the same time, the commission must present a survey of the uninsured, an evaluation of how well existing reforms are working, and a study of the factors that affect affordability.

Community Integrated Service Networks

The legislation gives small community-based networks a two-year head start to help them compete with the large health plans. A CISN is a "formal arrangement" licensed to provide prepaid health services to 50,000 or fewer enrollees. The commissioner of health will begin accepting CISN license applications July 1, 1994. CISNs may begin marketing as soon as they're licensed but may not start providing services until January 1, 1995.

CISNs must be rooted in their local community. At least 51 percent of the governing board members must live in the CISN's service area, and at least 40 percent of the board members must be consumers, elected by the enrollees.

CISNs must offer the HMO benefit set, but they may impose deductibles up to $1,000 per person per year on all but preventive health services.

CISNs' net worth requirements are slightly less than those of HMOs, and they may phase in their net worth over a three-year period. By contracting with accredited capitated providers who agree to accept risk, CISNs can reduce their net worth requirement.

Integrated Service Networks

Voluntary formation of ISNs "will begin after rules have been adopted, but not before July 1, 1996." By July 1, 1997, all health care must be delivered though ISNs, CISNs, or RAPO. The commissioners of health and commerce must develop ISN solvency standards and benefits set requirements no later than January 1, 1996. These subjects will be hotly debated next year.

Health Care Cooperatives

The MinnesotaCare Act creates yet another way to form integrated health care systems —health care cooperatives, which are based on rural agricultural co-ops. Originally proposed by the Minnesota Hospital Association, co-ops come in two varieties: 1)Health care network cooperatives formed by employers, individuals, or local units of government to buy health care coverage for their members. They may be licensed either as HMOs or as indemnity insurers. 2) Health provider cooperatives formed by providers, provider clinics, or hospitals to sell health care services on a capitated basis.

The co-op proposal offers physicians another way to form networks, but it is not clear how co-ops will be affected by federal antitrust and fraud and abuse laws. The MMA is analyzing the legal issues and plans to conduct seminars on the legal implications of cooperative arrangements.

Regulated All-Payer Option

The RAPO provision is improved, its emphasis shifted from cost cutting to choice. The act clearly states that RAPO's purpose is "to provide an alternative to integrated service networks for those consumers, providers, third-party payers, and group purchasers who prefer to participate in a fee-for-service system." The MMA urged that there be no tilt toward either ISNs or RAPO. The new language is a step in the right direction, but whether RAPO will really be a viable option will depend upon the RAPO fee schedule.

The RAPO fee schedule will be

Summary continued on page 36

Summary *continued from page 35*

phased in beginning January 1, 1996, and will be fully in place July 1, 1997.

The commissioner of health will adopt a RAPO fee schedule based upon the Medicare resource-based relative value scale (RBRVS), adapted to be Minnesota-specific. The commissioner will convene an advisory committee that includes "a broad array of health care professionals that will be affected by the fee schedule." The MMA intends to be at the table.

During the transition period, expenditure limits for health companies and revenue limits for health care providers will be set.

Self-Insured Capitated Products

A major new policy may allow physicians and health plans to form arrangements with large self-insured employers. A self-insured employer with more than 1,500 employees may offer capitated health plans without being licensed as an HMO. The size requirement drops to 750 employees in January 1995, and the provision sunsets December 31, 1997.

To be allowed to offer a capitated plan, the self-insured employer must agree to certain conditions, such as paying the 2 percent provider tax, the 1 percent premium tax that takes effect July 1, 1996, and the Minnesota Comprehensive Health Association assessments. The employer would also have to allow providers to pass the 2 percent tax on to third-party payers and comply with the data and administration simplification requirements in MinnesotaCare. The MMA is analyzing this new policy to see how it will affect physicans.

Purchasing Pools

Employers, groups, and individuals may form purchasing pools of at least 1,000 members to negotiate and buy health coverage. The MMA supports the creation of purchasing pools.

Expanded Network

Effective January 1, 1995, all health plan companies with more than 50,000 enrollees must establish an expanded network of "allied independent health providers" in addition to their preferred network. They must accept into the expanded network any allied provider who meets the company's credentialing standards, agrees to the terms of its provider contract, and agrees to comply with its managed care protocols. Companies may set limits on the number and length of visits, require patients to obtain a referral, and review and manage care. They may charge higher premiums and co-payments for the extended network as long as the charges are "actuarially justified and approved by the commissioner." Plans must pay the expanded network providers the same rate per unit of service as they pay providers in the preferred network.

The MMA opposed the concept of the expanded network because it will increase health plan costs. As enacted, however, the expanded network provision is much more flexible than the original proposal, and it does not apply to CISNs. The MMA had proposed a requirement that health plans offer their enrollees a point-of-service option that would allow them access to any health care provider, including any physician.

Ban on Exclusive Contracts

In a victory for the MMA, the legislation bans contracts that require the provider not to contract with any other health plan. The ban does not apply if the provider is an employee and does not affect exclusive contracts signed before the ban became effective. Existing contracts may be renewed. The exclusive contract ban sunsets January 1, 1997.

Health Plan Action Plans

To increase health plan accountability, the law requires licensed health plans to file an action plan each year beginning July 1, 1994. The action plan must include information on provider credentialing requirements, the number and type of health care providers, plans to improve quality, and plans to serve high-risk populations and rural communities. The state will publicize this information to consumers in hopes that they will compare health plans and make wise choices. The MMA supported this attempt to increase accountability and to make credentialing criteria public.

Provider Survey

The act calls for a pilot study to ask providers how health plans create "opportunities and barriers to the provision of quality, cost-effective health care." The provider survey will ask about administrative barriers, time spent getting permission for treatment, latitude to order tests and to refer to specialists, etc. The MMA supported this provision, which will give physicians a chance to tell their story.

Merger Moratorium

The act attempts to stop "merger mania" by imposing a moratorium on mergers by health plans that serve more than 5 percent of the insurance market in the state or more than 10 percent of the market in the seven-county metropolitan area. This may be a case of closing the barn door after the horse is long gone. The moratorium, which will expire July 1, 1996, would only prevent the three largest health plans, Allina, HealthPartners, and Blue Cross and Blue Shield, from merging with one another.

Data Simplification

Several provisions intended to reduce paperwork and cut administrative costs take effect January 1, 1996. Unless they are using an electronic data format, all institutional providers must use the HCFA 1450 form, and all non-institutional providers except dentists and pharmacists must use the HCFA 1500 form. All health care providers, provider organizations, group purchasers, and patients will be given unique identification numbers.

Universal Benefits Set

The commissioner of health in consultation with the Minnesota Health

Care Commission and the commissioners of human services and of commerce must develop a universal benefits set and present it to the Legislature by January 1, 1995. The commissioner will appoint an advisory committee to help develop the benefits set. The committee must include health care providers as well as purchasers, consumers, health plans, and counties. All health plans must offer the universal benefits set as an option beginning in January 1996, or as soon after that date as it is approved by the Legislature. The MMA will continue to recommend that the MMA standard benefits report be used as a basis for the state benefits set. As of January 1, 1997, all health plans must offer the standard benefits set within one of the five approved cost-sharing options, which may vary from a low-premium option with high co-payments to a high-premium option with low co-payments. Health plans may choose to offer separate supplemental coverage for other services.

Research and Education

The Medical Education and Research Task Force will continue for another year and must report to the Legislature by February 15, 1995. The MMA strongly urged the state to consider plans for research and education as part of health system reform so that institutions are not at a competitive disadvantage because of their research and teaching roles.

Workers' Compensation

The commissioners of health and of labor and industry must submit a plan to the Legislature by January 1, 1996, that incorporates workers' compensation health care into ISN coverage.

Rural Health Initiatives

The ISN Technical Assistance Program (ISNTAP) will provide seminars, start-up assistance, and access to a toll-free phone line for CISNs as well as ISNs. There is $212,000 available for start-up loans to CISNs, ISNs, or to networks less than one-year old. The summer health care intern program is expanded to include post-secondary, as well as high school students.

1994 MinnesotaCare Act Schedule

July 1, 1994

- Commissioner of health begins accepting CISN license applications
- Health plans must file action plans

January 1995

- CISNs may begin operation
- Universal benefits set recommendations are due to Legislature
- Commissioner of health's RAPO fee schedule is due
- Minnesota Health Care Commission's funding report is due
- Expanded allied health provider network required for health plans

January 1, 1996

- ISN solvency standards and benefits requirements must be set
- All health plans must offer the universal benefits set as an option
- Phase-in of the RAPO fee schedule begins

July 1996

- As soon as ISN rules are in place, ISNs may form
- MinnesotaCare and General Assistance Medical Care are integrated

July 1997

- All health care must be delivered through ISNs, CISNs, or RAPO
- RAPO fee schedule applies to services outside an ISN or CISN
- All Minnesotans are required to have health insurance
- Insurance reforms take effect
- All health plans must offer the universal standard benefits set within one of the five approved cost-sharing options

Essential Community Providers

Essential community providers (ECPs) will serve high-risk and special needs populations for five years. The MMA had recommended an extension of the proposed three-year sunset on ECPs.

Enrollment into MinnesotaCare

Beginning October 1, 1994, people with no children who earn no more than 125 percent of the federal poverty guidelines and who are not eligible for Medical Assistance may enroll in MinnesotaCare. This is a retreat from the July 1994 target date in the 1993 MinnesotaCare legislation and was made necessary by lack of funds.

Future Plans

The 1994 MinnesotaCare Act calls for many studies and reports to further define health system reform. The MMA will continue to play an active role as state planning goes forward. The MMA will continue to work through the Minnesota Health Care Commission and will push for physician representation on the various advisory committees that will help develop future plans. • • • • •

LEGISLATIVE NEWS

Provider Tax Repeal Bills Fail

Legislation that would have repealed the 2 percent provider tax and replaced it with an income tax increase was not heard on the floor of the House or Senate. The governor had told lawmakers he would veto the repeal legislation if it passed. The MMA will urge legislators to introduce similar legislation next year.

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Funding Bills Vetoed

Gov. Arne Carlson vetoed the MinnesotaCare funding bill that would have transferred $75 million from the General Fund budget reserve into the Health Care Access reserve account. The transfer would have allowed the MinnesotaCare program to enroll people with no children who earn up to 275 percent of the federal poverty guidelines beginning in July 1994. The MMA supported this bill, arguing that it was a transfer not a tax increase.

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Anti-Smoking and Other Health Proposals Vetoed

Anti-smoking legislation fell victim to the governor's ax when he vetoed the Health and Human Services Supplemental Funding Bill. This larger bill included an MMA-supported proposal to fund a public education campaign about the danger of secondhand smoke to children. The funding bill also included a provision that would have helped prevent the sale of cigarettes to children. It would have required cities to coordinate annual, random, unannounced inspections at locations where tobacco products are sold and would have required employers to inform employees who sell tobacco products about the laws and policies regarding tobacco sales. Because of the governor's veto, Minnesota could be found out of compliance with federal rules mandating the implementation of a retail inspection program. If this happens, the Department of Human Services could lose $1.5 million in funding for tobacco cessation programs.

The funding bill veto also eliminated a proposal for research on women's health needs and a program to reduce teen pregnancies. It cut a $70,000 appropriation for cervical and breast cancer screening for low-income women, and an increase in Medical Assistance payment to providers for administering childhood immunizations. Payment would have gone from $3.50 to $5 per dose if the vaccine was not obtained from the federal pediatric vaccine administration. A requirement that all acupuncturists who are not also medical doctors, osteopaths, or chiropractors must be certified was also cut. For further information about the impact of the supplemental funding bill veto, see "Carlson Vetoes Health Bill," page 55.

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Residency Requirements Relaxed

To help rural hospitals that are struggling to recruit physicians, the Legislature relaxed Minnesota's two-year residency requirement. Effective May 14, a new amendment to the Medical Practice Act allows physicians who have practiced for five years without disciplinary action to become licensed in Minnesota after one year of graduate clinical medical training rather than the standard two years. In addition, the applicant must have passed the Special Purpose Examination of the Federation of State Medical Boards within three attempts in the 24 months before licensing. The MMA convinced legislators to delete an additional provision that would have changed data classifications so that applicants for licensure would be allowed access to Board of Medical Practice data that licensed physicians cannot obtain.

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Use of HIV Test Results Banned

A new law designed to prevent discrimination against emergency medical services personnel who may have been exposed to HIV during the course of their duties takes effect August 1. Chapter 475 prohibits insurers from obtaining HIV-antibody test results of emergency medical service personnel and using them to make an underwriting decision or to cancel, fail to renew, or take any action regarding a policy, plan, certificate, or contract.

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Peer Review Law Modified

The Medical Practice Act was amended to clarify that medical societies are exempt from reporting requirements when they are conducting peer review as an agent of an outside entity, organization, or system. The MMA supported this provision, which allows the MMA to proceed with its external peer review services on behalf of clients without being required to report to the Board of Medical Practice.

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Smoking Ban to Take Effect

Beginning August 1, 1994, smoking will be prohibited in rental apartment buildings' common areas, including the hallways and recreation areas. The MMA strongly supported this expansion of the Clean Indoor Air Act.

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LEGISLATIVE NEWS

Volunteer Athletic Physician Immunity Granted

The MMA strongly supported the volunteer immunity bill, which ended up passing as part of the Omnibus Fish and Game Act. This provision grants immunity to volunteer team physicians or volunteer certified athletic trainers for damages to a player, participant, or spectator caused by care provided at the scene of a sporting event or during transportation to a hospital, physician's office, or other medical facility. Immunity is granted to the individual physician or certified athletic trainer, not to the sponsoring organization, and does not apply if the organization has insurance coverage. There is no immunity if the physician or trainer acts in a willful, wanton, or reckless manner.

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Spiritual Healing Protections Repealed

Parents who depend solely on spiritual healing to treat their children's illnesses will no longer be shielded from the child neglect law. According to the 1994 Omnibus Crime Act, a parent, guardian, or caretaker who knows or should know that a child's health is in danger and does not obtain medical care is guilty of a gross misdemeanor if the child suffers great bodily harm, and is guilty of a felony if the child dies. The act also repeals an exemption for parents who refuse on religious grounds the newborn tests required for all infants within the first 28 days after birth. The MMA supported this change in law, which takes effect July 1, 1994.

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Dispensing Authority Granted

As of August 1, physician assistants and advanced practice nurses will be able to dispense as well as prescribe and administer medical devices and legend drugs, including sample drugs, as long as the drugs are specifically listed in the written agreement with their supervising physicians. Physician assistants and advanced practice nurses have authority to prescribe, administer, and dispense only under direct supervision of a physician and in accord with a written agreement outlining their authority regarding specific drugs. This legislation is in line with MMA policy.

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Mandatory Malpractice Bill Not Heard

Neither of the two bills that would have required physicians to have medical malpractice insurance coverage received a hearing this session. One bill would have required proof that insurance had been purchased, and the other would have given authority to the Board of Medical Practice to determine liability limits. Last session, when mandatory malpractice was a hot issue, the MMA argued that it should be considered only as part of a comprehensive tort reform effort.

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Utilization Review for Workers' Comp Fails

As directed by the 1993 MMA House of Delegates, the MMA pursued legislation that would have expanded the Utilization Review Act of 1992 to apply to all workers' compensation utilization review decisions, but, unfortunately, the bill did not receive a hearing. The Utilization Review Act of 1992 sets uniform standards for organizations performing utilization review of medical procedures, but it does not apply to workers' compensation.

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Health Professionals Services Program Bill Signed

A new law allows the health licensing boards to form a Health Professionals Services Program, also known as the "diversion program." Designed for licensed health care workers who are unable to practice with reasonable skill and safety because of the use of alcohol, drugs, or chemicals, or because of a mental, physical, or psychological condition, the new program will provide the following services:

- referrals for evaluation and treatment;
- development of individual participation agreements, which may include a plan for continuing care, health or practice monitoring, practice restrictions, random drug screening, etc.; and
- monitoring of compliance.

Licensed providers may fulfill their requirement to report providers who are unable to practice with reasonable skill and safety by reporting to the program rather than to the licensing board. Anyone who reports to the program is immune from civil liability or criminal prosecution if the report is submitted in good faith.

Except for monitoring data, all data collected and maintained by the program is classified as "confidential" while the person is in the program. This means only the program will have access to the data. When the person completes the program by fulfilling the requirements of the participation agreement, the data is re-classified as "private" and becomes available to the subject of the data. The program can't forward data and agreements to the licensing boards unless the program is reporting a participant for a reason such as non-compliance or danger to the public.

The MMA worked closely with legislators and the licensing boards to achieve a final bill that protects the due process rights of physicians and other providers.

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LEGISLATIVE NEWS

Research Threat Defeated

The MMA and others convinced legislators to remove an amendment from the Omnibus Data Privacy bill that would have blocked research into the causes of infant deaths and set a precedent that could have jeopardized tens of millions of dollars in federal research money coming into Minnesota each year.

The amendment was added to legislation the Minnesota Department of Health sought so it could obtain the medical records of infants who were born dead or who died during the first two years of life and of their mothers to use for research purposes. To protect the families' privacy, names and all other identifiers would be removed from the records.

The MMA supported this bill, paving the way for research that could save babies' lives. The study is badly needed. Although Minnesota's mortality rate for white infants is the sixth lowest in the nation, its mortality rate for African-American babies is the highest. The MDH wants to find out why babies are dying and chart a course for prevention.

The bill sailed easily through committees and passed the Senate, but it hit a snag when the House adopted an amendment that would have required a parent's consent to obtain the medical records.

The Minnesota Medical Association, the Minnesota Department of Health, the Mayo Clinic, and the University of Minnesota convinced the conference committee to drop the consent provision from the final bill. They told conferees that eliminating some of the infant mortality data would invalidate the study. A consent requirement would block access to the very data that are most needed. Mothers who used alcohol, cigarettes, or drugs during pregnancy, or parents who were abusive to their infants, might be afraid to release the records even though their privacy would be protected. In addition, the consent requirement would set a precedent that could endanger the validity of future medical research projects and could cause the loss of National Institutes of Health (NIH) funding for research conducted in Minnesota. The NIH would be unlikely to fund research that was not statistically valid because it did not include an entire population.

As a compromise, conferees strengthened a requirement that the Department of Health must make a "good faith" effort to notify the parents. A public health nurse must be sent to the home to notify the parents, and if the nurse is unable to contact them, a certified letter must be sent. Short of obtaining a court order, however, the parents would not be able to block access to the medical records. The bill was signed into law by the governor.

In another research provision, the sunset on June 1, 1994, of the law allowing researchers to obtain access to medical records without patient consent was extended to 1996. The MMA supported this provision.

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Data Sharing Provision Defeated

After strong opposition from the MMA, a data sharing provision was killed on the Senate floor. Promoted by the attorney general and the health-related licensing boards, this data privacy bill provision would have granted the boards broad powers to share confidential and private data with law enforcement agencies, departments, political subdivisions, and other state and federal entities.

The MMA opposed the provision because it would have allowed unsubstantiated charges gathered for administrative purposes to be forwarded for possible use in criminal prosecution. The provision would have unraveled the data privacy guarantees that have been carefully crafted to allow the MinnesotaCare data collection efforts and the new diversion program for impaired health care providers to go forward.

On the Senate floor, Sen. Sheila Kiscaden, IR-Rochester, offered an amendment to delete the data-sharing provision. Sen. Linda Berglin, DFL-Minneapolis, strongly supported her amendment, citing the destructive effect the provision would have on state efforts to collect data that would allow consumers to compare various health plans.

The MMA argued that the attorney general already has the authority to obtain information necessary to pursue criminal allegations but must first demonstrate probable cause and obtain a search warrant.

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Pharmaceutical Penny-Pinching Under MinnesotaCare

A new law intended to cut health care costs requires pharmacists to dispense generic drugs in many cases and limits gift giving by wholesale drug distributors.

Michelle M. Boynton, J.D.

MinnesotaCare, the health system reform legislation that the Minnesota Legislature enacted in 1992, includes cost-containment measures that affect almost every segment of the health care industry. In the years to come, Minnesota health care organizations and practitioners will be expected to start penny-pinching to slow the growth rate of health care spending. The pharmaceutical industry has not been forgotten. This article reviews the two key cost-containment measures that directly affect health care practitioners and the pharmaceutical industry in Minnesota.

Generic Drug Substitution

When times are tight, many of us have purchased a cheaper generic brand of groceries instead of the more expensive brand name groceries. Minnesotans are now required to do the same with drugs. In the "old days" (prior to January 1, 1994), a pharmacist had the option of substituting a generic drug for a brand name drug, unless the prescription specifically indicated that it should be dispensed as written. Now, in the age of MinnesotaCare reforms, this option has become a mandatory requirement. As of January 1, 1994, pharmacists are required to substitute a generic drug for a brand name drug if the following four conditions are satisfied: 1) the prescriber has not specifically indicated that the prescription should be dispensed as written; 2) a less expensive generic equivalent drug is available in the pharmacist's stock; 3) the pharmacist determines that the generic substitute is therapeutically equivalent and safely interchangeable with the prescribed drug; and 4) the purchaser does not object to the substitution after the pharmacist has disclosed it.

As with every rule, there are a few exceptions. Under the generic drug substitution law, pharmacists are not required to substitute a generic drug in three circumstances, even though the law indicates that a substitution is required. First, the law does not apply if the drug will not be covered by the patient's third-party payer. Second, if the patient has a health plan that covers prescription drugs under a managed care formulary or similar practice the law does not apply. Finally, generic drug substitution is not required when dispensing the following eight drugs: Coumadin, Dilantin, Lanoxin, Premarin, theophylline, Synthroid, Tegretol, and phenobarbital. This generic drug substitution law is quite broad and will likely result in pharmacists dispensing generic drugs in many circumstances. If practitioners want to assure that generic drugs will not be substituted, they must be aware of this law and specify that the drug should be dispensed as written.

Gifts from Wholesale Drug Distributors

Another key pharmaceutical cost-containment measure is directed at wholesale drug distributors. Minnesota law defines a wholesale drug distributor as "anyone engaged in wholesale drug distribution including, but not limited to, manufacturers; repackers; own-label distributors; jobbers; brokers; warehouses, including manufacturers' and distributors' warehouses, chain drug warehouses, and wholesale drug warehouses; independent wholesale drug traders; and pharmacies that conduct wholesale drug distribution." A wholesale drug distributor does not, however, include a common carrier or an individual who is hired primarily to transport prescription drugs.

Wholesale drug distributors must closely watch their gift-giving habits. As of January 1, 1994, all wholesale drug distributors are prohibited from giving or offering to give practitioners any "gifts of value." The determination of whether or not a gift has value is often a subjective concept; however, under MinnesotaCare, it is probably safe to assume that almost any gift has value.

The only time you can be certain a gift is not prohibited is if it qualifies for one of the following seven exceptions provided under the law: 1) professional samples of a drug provided to a prescriber for free distribution to patients; 2) items with a total combined retail value in any calendar year of not more than $50; 3) a payment to the sponsor of a medical conference, professional meeting, or other educational program, provided the payment is not made directly

to a practitioner and is used solely for bona fide educational purposes; 4) reasonable honoraria and payment of the reasonable expenses of a practitioner who serves on the faculty of a professional or educational conference or meeting; 5) compensation for professional or consulting services of a practitioner in connection with a genuine research project; 6) publications and educational materials; or 7) salaries or other benefits paid to employees. Any gift that does not fall within one of these categories is likely to be prohibited.

If a wholesale drug distributor gives a gift that qualifies for one of the seven exceptions, the distributor may need to inform the Board of Pharmacy. Wholesale drug distributors are required to file an annual report with the board identifying any payments, honoraria, reimbursement, or other compensation that the distributor has given during the preceding calendar year to a sponsor of an educational program, to a practitioner who serves on the faculty at an educational meeting, or to a practitioner who provides consulting or professional services for a research project. The report must identify any practitioner who received payments totaling $100 or more and must indicate the nature and value of the payments. The first annual report will be due at the end of the 1994 calendar year.

Conclusion

Cost containment is the central theme underlying the MinnesotaCare legislation and is the goal of the pharmaceutical penny-pinching laws. The Legislature hopes to contain pharmaceutical costs by increasing the use of less expensive generic drugs and decreasing the perks that drug distributors give to health care providers. Pharmacists, drug distributors, and providers should be familiar with these new laws and modify their practices and policies accordingly. MM

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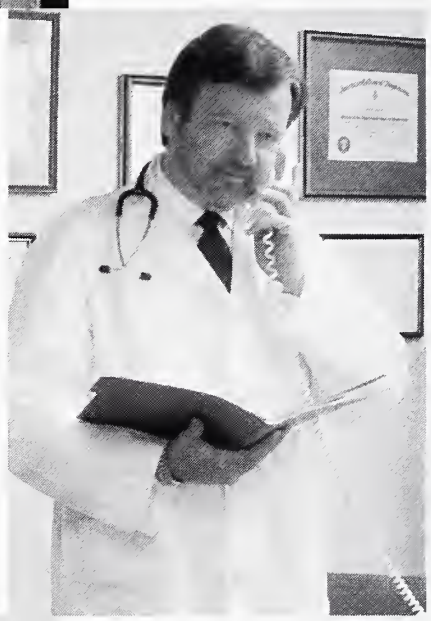

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Physician Prescribing Practices

Rx for Potential Pitfalls

Physicians should periodically evaluate their prescribing practices to prevent complaints and malpractice claims.

Gail F. Brandt, J.D.

Prescribing medication for patients is part of the daily routine for most practicing physicians. Each day thousands of prescriptions are written as part of good patient care. Not surprisingly, then, physicians sometimes find their prescribing practices the subject of a patient care controversy or the basis of a disciplinary action. In the last two years, at least 13 percent of the complaints lodged with the Minnesota Board of Medical Practice (BMP) related to prescribing issues. Most of the complaints could have been avoided by more careful management of prescribing practices.

Physicians should periodically evaluate their prescribing practices to prevent falling into a routine that leads to complaints or to malpractice claims. Physicians are rarely required to appear before the board because they prescribed the wrong medication or wrong dosage. Instead, most complaints and disciplinary actions result from mismanaging prescribing practices.

Medications With Potential for Abuse

Problems commonly arise with medications that have a potential for abuse and dependency, such as analgesics and anti-inflammatories like Darvocet-N, Percodan, Tylenol No. 3, Xanax, Prozac, and prednisone. While their therapeutic value is widely recognized, these medications also share the characteristics that often lead to a prescribing problem: They are often used regularly over a period of time; their prolonged use can lead to chemical dependency; and they are often used in response to the patient's subjective complaints of pain. These characteristics contribute to the potential for abuse, and the physician's prescribing practices may facilitate or enable the abuse.

Lack of Documentation

Documentation—or the lack of it—is the most common thread in prescribing problems. Physicians often fail to adequately document the medications prescribed for patients or to track refills. The Board of Medical Practice has suggested graphing patient medications to permit easier monitoring of patient records.

Prescription Refill Practices

Refilling prescriptions without seeing the patient or evaluating the records is another common problem, particularly with medications used for chronic pain or chronic ailments. Imagine how awkward a physician might feel explaining to the board why he or she repeatedly prescribed Tylenol No. 3 over a period of two years when the patient was only examined once during that time. Physicians should require periodic patient evaluations as a prerequisite for certain refills and should keep good records of those evaluations.

Drug-Seeking Patients

Controlling the supply of medications that have the potential for dependency is also an important aspect of managing medications. Unfortunately, physicians don't always identify drug-seeking patients. They should be wary of patients who ask the on-call physician to renew a prescription, who use medications faster than prescribed, who accidentally drop pills down the toilet, or who often lose prescriptions. These actions, as well as a history of chemical dependency and a pattern of frequently changing physicians, are signs of drug-seeking behavior, and physicians should closely monitor the medications prescribed for these patients. Physicians must maintain control of the medication dosage and use. They should base their choices on professional judgment and should consider alternative courses of treatment.

Prescribing for Family Members

Generally, physicians should refrain from prescribing medications for themselves or family members. The Board of Medical Practice is concerned about such practices, especially when the drug has dependency potential or the physician has demonstrated a pattern of repeated poor prescribing practices. The Council of Ethical and Judicial Affairs of the American Medical Association has

issued an opinion on the topic that advises physicians to avoid prescribing for family members because the physician's professional judgment and objectivity may be compromised. Prescribing for family members has some of the same pitfalls as other prescribing problems. Documentation is generally poor because the family member does not have a formal office visit. There tends to be no record of a diagnosis, treatment plan, or consideration of alternatives. The prescription is often intended as a temporary solution, but physicians and their families lead busy lives, and it is easy to lose track of those prescriptions. The physician may also be too close to the family member to recognize drug-seeking behaviors or, when self-prescribing, may not recognize his or her own abuse of medications.

Management of Prescription Forms

Pre-signing blank prescription pads or prescriptions that are incomplete can also cause problems for physicians. Although most such cases involve prescriptions for drugs with chemical dependency potential, this practice has also been reviewed for topical medications. Prescription pads should not be left in areas where patients or others can pick them up. Stolen prescription pads are often used by forgers to write their own prescriptions.

Drug-seeking individuals also may alter written prescriptions. In an effort to control the abuse of prescription drugs, state law now requires pharmacists to take a more active role in the management of patient medications. They may call the prescribing physician to verify the prescription or to get more information about the patient's medication history or treatment plan. Pharmacists are expected to counsel patients on their medications and to identify patients with drug-seeking behavior. Physicians should treat pharmacists as members of the patient's health care team, because they can assist in monitoring the patient's prescriptions as well as improve overall prescribing practices.

Delegation of Prescribing Authority

Another area of potential concern is the supervision of nurse practitioners and physician assistants. Physicians may delegate prescribing and administering functions to a physician assistant or nurse practitioner. In addition, because of a change in Minnesota law, beginning August 1, 1994, physician assistants and nurse practitioners will also be permitted to dispense or receive drugs. This means they may give drug samples to patients, which they had not been permitted to do under the prior law. The supervising physician must have a written agreement with the physician assistant or nurse practitioner that states the prescribing functions delegated to the physician assistant or nurse practitioner.

> "Problems commonly arise with medications that have a potential for abuse and dependency, such as analgesics and anti-inflammatories."

The Minnesota Medical Association and Minnesota Nurses Association have a memorandum of understanding regarding the requirements of the agreement. The authority delegated to the nurse practitioner or physician assistant should depend upon the knowledge and experience of the nurse or assistant and the trust and practice style of the physician. The agreement must be developed jointly by the physician and the nurse practitioner or physician assistant and should be reviewed at least annually. The agreement should identify each drug or device the nurse or physician assistant may prescribe, give directions regarding refills, and describe any other limitations on the delegated prescribing authority.

Drug Treatment

The BMP also receives complaints when physicians prescribe methadone as part of detoxification treatment. Only physicians who are specifically registered and meet the regulatory standards of a narcotic treatment program may dispense directly or administer methadone or other similar controlled substances to a drug-dependent person for detoxification or maintenance treatment. A physician who is not registered to conduct a narcotic treatment program may only administer the medication for three days, one day at a time, for acute withdrawal symptoms while making arrangements for referral.

Physicians may prescribe methadone or other controlled substances for pain management, but not as part of drug treatment. Thus, recording the diagnosis and purpose of the medication in the patient record is important.

Avoiding the Pitfalls

What can you do to prevent these prescribing problems? The Board of Medical Practice published guidelines in a 1990 BMP newsletter article, "The Management of Prescribing." Based on these guidelines and our experience representing physicians in disciplinary actions, we offer this prescription for avoiding potential pitfalls in prescribing practices:

Keep good medical records. Document the diagnosis, treatment plan medications, and prescription refills. Be sure you document refill requests from the patient and your review of the record. Consider graphing medication use, especially for those patients requiring prolonged use of analgesics, anti-inflammatories, or any drug with addictive potential.

Monitor the patient's progress. Require the patient to have regular office visits as a part of the treatment program. An office visit is not required for every prescription refill, but you should identify how frequently and under what conditions the patient should be seen. You may delegate some of this responsibility to nurse practitioners or physician assistants. Be sure they know they are responsible for monitoring the

patient's medications so this task doesn't slip through the cracks. Work with the patient's pharmacist to monitor the use of medications. This can be particularly helpful when patients have prescriptions from more than one physician.

Consider alternative treatment plans. Non-addictive methods may be available for managing the patient's treatment, and you should evaluate their appropriateness. Be sure to document your considerations and the reasons for your decision.

Be cautious about patients exhibiting drug-seeking behavior. Even though you might assume drug-seeking behaviors would seem obvious, or you might consider yourself an expert at spotting such behavior, you should review the patient's chart periodically. Physicians looking back over charts after a prescribing problem has arisen often recognize suspicious patterns or warning signs that they had missed in their day-to-day practices.

Talk to the patient. Physicians sometimes don't take enough time to discuss the risks of certain medications or counsel patients regarding all medications—not just those that are potentially addictive.

Don't prescribe medications for yourself or your family. Although it may seem harmless to occasionally prescribe medication for yourself or your family, it is too easy to lose sight of your professional judgment. In addition, documentation tends to be inadequate in these situations.

Delegate prescribing authority carefully and supervise your staff. Establish protocols and clear communication regarding the scope of your staff's prescribing and administering responsibilities. It is your obligation as supervisor to monitor their prescribing practices.

Conclusion

Benjamin Franklin's adage "an ounce of prevention is worth a pound of cure" is appropriate for prescribing practice problems. Most disciplinary actions or complaints related to prescribing practice are based on how the process was managed—not the physician's judgment in diagnosis or treatment plan or selection of medication. If you take some time to assess your prescribing practices, you'll be far less likely to get a call from the Board of Medical Practice. If you do receive an inquiry from the board, you should treat it seriously, but you should also remember that an inquiry does not mean the board has concluded there is a problem. MM

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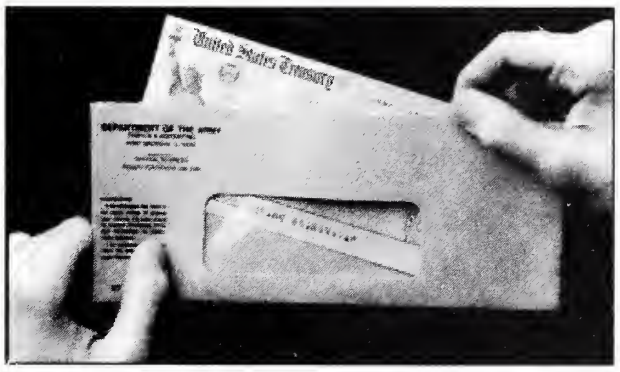

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Strategies for Reforming the Health Care System

Many remedies have been proposed for curing our nation's health care ills. This month, we take a look at a variety of proposals and analyze how managed competition is being used in Minnesota.

Janet Silversmith

While Congress and state legislatures wrestle with the details, it is increasingly apparent that health system reform is inevitable and, for Minnesota, imminent. The first article in this Health Reform Series[1] described numerous reasons for reforming the system. The far more difficult question is: How can reform be best accomplished? The following article uses a framework developed by Soffel and Luft[2] to describe some of the remedies proposed to cure our nation's health care ills. The leading proposal, managed competition, is also discussed: Where did it come from? What is it? And how is it being refined in Minnesota?

A Framework for Analysis

Fixing what ails the U.S. health care system is a daunting challenge; nevertheless, numerous proposals have been put forth, ranging from incremental to fundamental change. Many of the proposals are deeply rooted in strong ideological and philosophical principles; others represent a hybrid approach to change. Given the intense and emotional reactions health care reform debate often produces, it can be difficult to compare proposals objectively. Denise Soffel, Ph.D., and Harold Luft, Ph.D., developed a framework for comparison based on two primary dimensions—1) enrollment/eligibility and 2) organization of the delivery system. This framework provides a very basic but clear starting point for examining some of the fundamental differences among the health system reform options currently being discussed.

Enrollment and eligibility

Soffel and Luft define four specific models of enrollment and eligibility to describe the means by which people get into the system, how they obtain coverage, and how payment to the system is made.

- **Model 1**, which encompasses individual enrollment and voluntary eligibility, calls for individuals to obtain their own insurance coverage. Employers are not required to offer coverage, although they could offer vouchers or add income to wages for the purpose of obtaining coverage. Low-income individuals could receive tax credits from the government to assist them in purchasing coverage. Soffel and Luft identify the Bush administration's voucher-tax credit plan as an example of this model. The conservative Heritage Foundation supported a variation of the model that included mandated eligibility, i.e., individuals would be legally responsible for obtaining a basic level of coverage.
- **Model 2** is the approach currently used in the United States. Under this model, enrollment is employer-based and eligibility is voluntary. Employers are not required to provide health insurance to employees, but many do. Many small businesses find the cost of offering coverage to be prohibitive. Many individuals, both employed and unemployed, fall through the gaps in a voluntary approach. Government-sponsored programs and personal out-of-pocket payments help finance this model.
- **Model 3** calls for employment-based enrollment and mandatory eligibility with "gap" programs. This model builds on model 2 by maintaining the employer-based system. Model 3 goes one step further by mandating that all employers provide coverage. Government or "gap" programs would be included in this scenario to cover individuals outside the work-based system.
- **Model 4** is a universal, tax-based system. In this approach, Soffel and Luft imagine the separation of employment and insurance coverage. All individuals would be covered by a comprehensive program financed through the tax system, perhaps using payroll, income, sales, and excise taxes.

Delivery system

The second dimension to Soffel and Luft's framework is the organization of the delivery system. They offer seven models to define the way providers (individual and institutional) are paid and organized to provide care; the way quality assurance is managed and information is disseminated to consumers; and the way global budgets are used. The first three models do not include a global or national budget; rather, these models seek to achieve cost containment through managed care practices, a competitive marketplace,

administrative simplification, and improved information to consumers. The last four models are similar in structure but include the use of a global budget in some capacity.

• **Model 1** reflects the status quo in many parts of the country, or a very modest approach to reform. The dominant provider compensation mechanisms—fee-for-service, salary, and capitation—remain. Most providers are organized in solo or group practices. Managed care systems may be developed and encouraged, but they are not required. Cost containment is minimal and may be managed through benefit reductions and utilization review.

• **Model 2** starts to move the delivery of care into managed care systems. Fee-for-service is not eliminated in this model; however, it is envisioned that fee-for-service becomes less competitive with managed care systems.

• **Model 3,** the last model without a global budget, is described by Soffel and Luft as actively managed competition, the proposal originally developed by the Jackson Hole Group.[3] This model is premised on the notion that a competitive (and reformed) health care market can serve to control costs and improve quality. To promote competition in the market, this model calls for organizing and informing consumers and establishing rules for all managed care systems. Physicians, hospitals, and insurers form partnerships that compete for consumers by offering (and proving) the highest quality for the lowest price. Each partnership determines the organization of professional services and reimbursement for providers.

• **Model 4** calls for all providers to be salaried. Care is delivered through managed care settings, and the system operates under a national budget. Although not a perfect example, the Department of Veterans Affairs could be considered this type of organizational model.

• **Model 5,** with fee-for-service providers and a national health budget, calls for continuing a variety of the existing provider compensation approaches and maintaining a variety of health care structures in which managed care settings are not required. The model subjects providers to budget caps, however, and fees may be forced down to meet the budget requirements.

• **Model 6** expands model 5 by further developing managed care systems but allowing fee-for-service as an option. The model calls for placing managed care plans at risk for containing costs, while fee-for-service providers operate under a fee schedule.

• **Model 7** is defined as actively managed competition with a national budget. Again, physicians, hospitals, and insurers form partnerships. Organizations develop to provide cost and outcomes data to consumers. A national budget is used to control or cap premiums and to regulate the rates charged by providers.

The matrix displays Soffel and Luft's models as a matrix and shows where various existing health care programs would be placed. Because the framework cannot capture subtle differences among programs, many of the plans fall between categories.

A Brief History of Managed Competition

The concept of managed competition was developed primarily by Stanford University economist Alain Enthoven and the Jackson Hole Group. Many variations of managed competition have been proposed in health system reform debates, and changes in a few components can shift a proposal's placement on the matrix. Minnesota, for example, has advanced its health system reform efforts under the term managed competition. On the matrix, however, the Minnesota and Jackson Hole proposals are fairly far apart. To help reduce confusion over the term managed competition, a brief review of the Jackson Hole Group's original version of managed competition follows. Minnesota's variation on that theme is then examined in comparison.

Alain Enthoven contends that competition in health care has not yet been tried, while many others argue that competition has failed.[4] Insurance reduces the effectiveness of competition in health care, says Enthoven. That is, insurance insulates individuals from the true costs

	NO EXPLICIT BUDGET				NATIONAL HEALTH BUDGET			
ENROLLMENT/SYSTEM	SALARIED	FEE-FOR SERVICE	MANAGED CARE	ACTIVELY MANAGED CARE	SALARIED	FEE-FOR SERVICE	MANAGED CARE	ACTIVELY MANAGED CARE
INDIVIDUAL, VOLUNTARY								
							MINNESOTA	
EMPLOYMENT-BASED, VOLUNTARY		CURRENT U.S.						
EMPLOYMENT-BASED, MANDATORY WITH "GAP"				JACKSON HOLE		GERMANY		
TAX-BASED					V.A.	CANADA		

Soffel and Luft matrix of health care programs and proposals.

of care, particularly after they have met their annual deductibles. The cost of care beyond that point is often zero, creating an incentive to purchase more care than one might buy if paying for it directly. Enthoven further states that managed care systems, such as HMOs, were developed to counteract this "cost-unconscious" demand. The problem, he argues, is that HMOs have not succeeded in reducing national health care expenditures because purchaser practices, tax laws, and other market imperfections have created conditions that make the demand curves for HMOs price-inelastic (a change in price has little effect on the demand for the product). As a result, HMOs have no incentive to cut cost and price.

In other words, if HMOs increase premiums, they keep about the same number of enrollees and make more money. They have an incentive to increase prices. Conversely, if HMOs had elastic demand (where price greatly affects demand for the product), they would have an incentive to reduce premiums and gain more enrollees in order to increase revenue. Enthoven directs his proposal for reforming the health care system specifically at efforts to change the price-inelastic demand curve.

A recent article in the *American Journal of Public Health*[5] maintains that the actual origins of managed competition are found in the systems analysis and planning-programming-budgeting system (PPBS) that Enthoven helped develop at the Department of Defense during the 1960s. While there may be similarities, the managed competition concept for health care did not emerge until 1977, when Enthoven presented what was then called the "Consumer Choice Health Plan" or "regulated competition" to the Carter administration.[6] This original version was built on the prepaid group practice and the HMO concepts of the early 1970s. Over time, Enthoven refined the proposal and, in the course of being challenged on its adaptation to a particular environment, decided that many of the concerns could be "managed," so he changed its name to managed competition.[7]

In 1991, Enthoven's vision of managed competition became the cornerstone of the Jackson Hole Group's reform proposal. A legislative assistant to Rep. Jim Cooper, D-Tennessee, was present at one of the Jackson Hole Group meetings. Cooper pursued the proposal and, with the 65-member Conservative Democratic Forum (a group of conservative Democrats in the House and Senate), introduced the Managed Competition Act of 1992. The primary difference between the CDF proposal and the Jackson Hole proposal was that CDF did not call for an employer mandate, as the Jackson Hole proposal did.[8] Managed competition would later emerge as the basis for President Clinton's health care campaign.

"Alain Enthoven contends that competition in health care has not yet been tried, while others argue it has failed."

Key Elements of Managed Competition

A central component of managed competition is the need to create effective competition. Enthoven notes that a health care market dominated by health plans and financing systems on the supply side and individual consumers on the demand side cannot work.[7] Managed competition seeks to organize the demand side, provide incentives to the suppliers, and establish rules for the conduct of business. Managed competition has two key elements: integrated financing and delivery structures (ISNs in Minnesota, accountable health plans in the Clinton plan), which will compete on the basis of quality and price; and health insurance (or health plan) purchasing cooperatives (HIPCs or HPPCs), also known as purchasing pools or alliances. Enthoven described additional details, including standardized benefits packages, risk-adjusted premiums, production of reliable data on quality, and limits on the tax subsidy on health insurance benefits.[7]

The HIPC, or regional alliance in the Clinton plan, is viewed by many people as a central feature of the proposal. This component also generates the most discussion because it is difficult to understand and, possibly, to implement. HIPCs are best viewed as purchasing agents with the economic clout to negotiate the best rates for individuals and employees of smaller firms.[6] The concept raises several concerns: Should the use of a HIPC be voluntary or mandatory? Should all employers regardless of size use a HIPC? Should it be a for-profit or nonprofit entity? The Clinton plan currently requires all employers with fewer than 5,000 workers to participate in the regional alliances. One often cited example of a functioning HIPC-type program is the California Public Employee Retirement System (CalPERS), a successful private-sector program that has managed to maintain and even reduce premiums.[9] Minnesota's Public Employee Insurance Program also is identified as a HIPC-type program.

The managed competition proposal contains many other important elements, but the key components described above distinguish it from other proposals, such as the single-payer option.

Managed Competition in Minnesota

Minnesota has embarked on a health system reform course known as MinnesotaCare. Using Soffel and Luft's framework as presented in the table, Minnesota falls between the individual/voluntary enrollment and the employment-based/voluntary enrollment models, and it falls between the managed care and the actively managed care organization models. MinnesotaCare's placement is linked not only to policy decisions, but also to legal and political realities.

The Minnesota Health Care

Commission, a group that advises the state Legislature on specific health system reforms, favored building on the existing employer-provided system of coverage to achieve universal access. The problem, however, is that states do not have authority to expand or mandate employer-based coverage because of the federal Employee Retirement Income Security Act (ERISA) of 1974. In an effort to seek universal coverage, however, the commission recommended using an individual mandate. It is possible that Minnesota's position on the matrix could shift down to the employment-based, mandatory with "gap" category if national mandates are successful.

On the organizational dimension of Soffel and Luft's framework, Minnesota falls between managed care and actively managed care with a national health budget. The 1993 Legislature clearly articulated a vision for Minnesota's reformed health system with the introduction of integrated service networks. ISNs are envisioned as organizations that integrate the delivery of care and insurance functions. In general, an ISN will consist of a group of physicians, a hospital, and a health plan that will provide a full spectrum of health care services for a predetermined rate and will be accountable for the costs and outcomes associated with the delivery of care to enrollees. ISNs will have the ability to determine providers' compensation and to determine the criteria by which providers may join. Alone, the ISN portion of Minnesota's reform proposal is a nearly perfect example of Soffel and Luft's actively managed competition model. Other components of Minnesota's approach that fit into this category include the Data Institute (an entity that is being created to collect and distribute standardized information on costs and quality) and the implementation of growth limits on both providers and payers.

Other elements of Minnesota's health reform approach make the fit less clean. For example, although ISNs are the delivery systems of choice for the architects of Minnesota's plan, an important fee-for-service option remains in the proposal—the regulated all-payer option (RAPO). Providers operating in RAPO are anticipated to work under a uniform fee schedule, which allows the state to meet the requirements of the global budget.

Minnesota's version of managed care also lacks a comprehensive reform plan for the purchasing side of the equation because states are hindered by ERISA in reforming aspects of the market. Minnesota's proposal advocates voluntary purchasing pools to form under certain conditions but is much more heavily focused on the delivery structure. Nevertheless, several purchasing programs have developed in Minnesota among large employers, small employers, and public employees. For true competition to occur among the ISNs, Enthoven would argue, organized purchasing pools must be further developed and managed to ensure power on the demand side.

Remaining Questions About Managed Competition

Some variation of the managed competition approach to health care reform is likely to occur at both the state and federal levels. Although policymakers have embraced many aspects of the proposal, managed competition faces many obstacles. One significant concern is the effect the political process will have on this carefully defined economic model. Other issues that bear noting include how high-risk, chronically ill, and mentally ill individuals will fit into the system; how self-insured plans will fit into the equation and whether competition will be effective if they remain outside the new structure; how quality can be effectively measured and compared given limited data and techniques; and, perhaps most important, how managed competition will work in rural areas, where access, not competition, is the primary concern.

Richard Kronick, Ph.D., an early contributor to the managed competition theory, has argued that managed competition is likely to work only in medium-sized or large metropolitan areas.[10] Kronick has also indicated that the minimal population necessary to support a classic HMO offering referral hospital services and using its own staff physicians is about 450,000 enrollees. Kronick et al. wrote that a market with a population of 1.2 million could support three fully independent health plans and likely make competition work. In 19 states, however, the majority of the population lives in areas inhabited by fewer than 180,000 people, where hospital services would have to be extensively shared. In Minnesota, approximately 36 percent of the population lives in a market area with fewer than 180,000 individuals. Most likely, alternatives to managed competition will need to be developed for rural areas. The next article in our series of health reform reports (in the July *Minnesota Medicine*) will discuss various rural health care delivery strategies. MM

Janet Silversmith is a health care policy analyst for the MMA.

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The Role of Professionalism in Health System Reform

C. Randall Nelms Jr., M.D.

The heart of professionalism is adherence to a set of standards or code of ethics higher than the law or marketplace would require, leading to public esteem and trust. This trust provides the foundation for the physician-patient relationship and reduces the government's inclination to intrude into professional matters.

The medical profession has worked hard to earn trust by establishing standards of education and medical practice that physicians follow. The profession has done a good job of self-regulation despite such handicaps as antitrust laws, the legal system, and the government's sometimes inconsistent regulatory efforts.

The medical profession has created an excellent structure for self-regulation, consisting of accreditation agencies, hospital medical staffs, and professional associations representing a large network of physicians. The bulk of doctors in organized medicine voluntarily participate in self-regulation every day. This structure is not well-known or appreciated outside the profession, or even by many physicians.

The structure of self-regulation within the medical profession is divided into two parts. One deals with establishing standards for the profession, and the other deals with enforcing those standards.

The AMA was founded with the primary purpose of improving medical education in this country, and, ultimately, of improving the medical care provided to the public. Before the AMA was organized, there were no established standards for medical education. Moreover, a person wishing to practice medicine was not required to attend a bona fide medical school. In 1904, the AMA established a Council of Medical Education. The council published its first standards, now called "essentials," in 1910. They included admission criteria, faculty qualifications, and record keeping. We now have strong, viable, cooperative groups setting standards for education, such as the Accreditation Council for Continuing Medical Education, the Accreditation Council for Graduate Medical Education, and the Liaison Committee on Medical Education, to name just a few.

"Health system reform cannot succeed unless it preserves and bolsters physician professionalism."

In addition, the AMA and other medical societies have established codes of ethics, medical practice standards, and patient safety standards. These and other professional standards are enforced through accreditation, hospital medical staff credentialing, quality assurance, codes of ethics, peer review, and disciplinary procedures.

The standards of professionalism are largely self-executing. If they are known, physicians will abide by them. But they are not always known or understood, and they need to change with new developments in medicine and society. The profession's ability to follow through with effective enforcement actions when necessary will enhance the public's and policymakers' understanding of self-regulation and create greater respect for the profession.

We are at a critical time in the history of our profession with health system reform on the horizon. The medical profession's self-regulatory structure is a vital part of the system, and neither we nor our patients want to lose it. In fact, health system reform cannot succeed unless it preserves and bolsters physician professionalism.

We must earn autonomy by observing certain standards of behavior. We are expected to put the patient's interests before our own. We also must be committed to self-improvement—mastering new knowledge about medicine and incorporating it into our practice. The most important mechanism to promote self-improvement in our profession is research. New knowledge increases our sense of mission and offers hope for curing untreatable illness in the future. Health system reform must support and reward effective peer supervision, education, and discipline. Because of our specialized knowledge, physicians are uniquely positioned to supervise the work of peers.

Regardless of what reforms we institute, patients must enter their physician's office with confidence. They must have trust in their physician's goodwill, integrity, and competence. This trust can best be preserved if physicians uphold high standards of professionalism. MM

Minnesota Medicine is the official journal of the Minnesota Medical Association, and its purpose is to provide Minnesota physicians with timely information regarding all aspects of medicine so they can more capably serve their patients and more readily achieve their professional goals. Therefore, the editors are pleased to consider for publication clinical and health papers (clinical studies, reviews, case reports) and essays, letters, poems, and opinion pieces related to medical practice in Minnesota.

Manuscripts

Submit clinical articles, essays, letters, book reviews, and other manuscripts at any time to: Meredith McNab, Managing Editor, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. Manuscripts are reviewed by the editors and peer reviewed by the Advisory Committee, the Review Board, and other experts in particular specialties.

Please submit two copies and keep one for your files. You may submit a Macintosh or IBM-compatible ASCII (text) floppy disk with your manuscript. Disks and copies of unpublished manuscripts will be returned to the authors. Only submit unpublished articles that have not been submitted elsewhere.

A cover letter should identify the author with whom we correspond (include address and phone number). Double-space all text on one side of paper only, including references, legends, etc., and number pages consecutively.

Receipt of manuscripts is acknowledged within 10 days, and authors are usually notified whether their manuscript is accepted within one to three months, but longer delays are sometimes unavoidable.

Title and Authors' Names

The first page of the manuscript should include: 1) a title—make it short, specific, and direct, 2) the full names of all authors, with their academic degrees, 3) authors' positions in hospitals or other institutions—include current position and the position held when the work reported in your manuscript was done, as well as academic appointments and other information pertinent to the paper's topic.

Abstract

The second page of the manuscript should include an abstract no longer than 150 words that highlights for the reader the essence of the authors' work. It should focus on facts rather than descriptions and should emphasize the importance and uniqueness of the findings and briefly list the approach used for gathering data and the conclusions drawn.

Author Responsibility

All authors should be involved in the drafting, revision, and intellectual content of the manuscript and be sufficiently familiar with the paper to defend its findings. Authors are responsible for all statements made in their work, *including changes made by copy editors*. Manuscripts are edited for clarity and grammar and to conform to *Minnesota Medicine* style, and authors receive an edited, word-processed copy of their paper for review before it is sent to the printer. Once it is set in galleys, only *minor* changes can be made.

All authors sign a copyright form that conveys all copyright ownership to the Minnesota Medical Association. This form is mailed to the authors after a manuscript is submitted to *Minnesota Medicine*, and must be completed and returned before the article is published. If the manuscript is not accepted for publication, the form is returned to the authors.

Style

Use *JAMA* style or consult the AMA's *Manual for Authors & Editors*. Use generic drug names, unless citing a brand name relevant to your findings; brand names in parentheses may follow generic names if desired. Do not use abbreviations in the title, and limit their use in the text. Avoid medical jargon.

Tables

Tables must have a title and be on separate pages. If they occupy more than one page, type "*title* (cont.)." If the data in the tables have been previously published, appropriate reference should be given in the text, and permission should be obtained from the original publisher before submission to *Minnesota Medicine*.

Illustrations

Submit two copies of illustrations, keeping one for your files. Figures should be professionally drawn or photographed, if possible. We prefer glossy, clear black-and-white photographs, but color is acceptable if the contrast is good. Do not send original artwork.

Each figure should have a label pasted on the back indicating the figure number, author names, and the top of the figure. Legends should be included in the text of the manuscript with numbers corresponding to the figures. Do not mount figures on cardboard, write on the back of the figures, or attach paper clips to them. If a patient in a photo is identifiable, a written release form from the subject must accompany the photo.

References

All references must be cited in the text and should be arranged in the order in which they are cited in the text—*not* alphabetically. Journals should be abbreviated as in *Index Medicus*.

Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. Mayo Clinic Proc 1986;61:859-64.
2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. Dis Colon & Rectum, to be published.
3. Chaterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.
4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. Pediatric Surgery, 4th ed. Chicago: Year Book Medical, 1986: vol 1, 522-33.

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List all affiliations with or financial interest in organizations that may have a direct interest in the subject matter of your manuscript. This information will be held in strict confidence until publication, and then will be printed with the article as is deemed appropriate in judging the validity of the article.

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People and Places Making Medical News

People

National Trauma Chair

The American College of Surgeons Committee on Trauma has appointed **John Weigelt, M.D.**, the chief of surgery at St. Paul-Ramsey Medical Center, to chair its committee of 40 trauma specialists. The committee represents 66 regional subcommittees and will oversee standards relating to trauma care. Weigelt also serves as vice chair of the department of surgery at the University of Minnesota.

Ramsey Clinic Director

Ramsey Clinic, sister corporation to St. Paul-Ramsey Medical Center, has hired **Robert K. Knopp, M.D.**, emergency medicine, as its director of education. Knopp comes to Ramsey from Valley Medical Center in Fresno, California, where he was associate chief of emergency medicine and clinical professor of medicine at the University of California, San Francisco.

Abbott Northwestern 1994 Board

Abbott Northwestern Hospital has appointed new medical board officers for 1994: **Frazier Eales, M.D.**, president; **James Larson, M.D.**, president-elect; **Jane West**, M.D., secretary; and **Donald Blowers**, treasurer. Ronald J. Peterson, M.D., is immediate past president. The department chairs are as follows: **Mark Nissen, M.D.**, anesthesia; **Marc Pritzker, M.D.**, cardiovascular diseases; **David R. Peterson, M.D.**, emergency medicine; **Donald Blowers, M.D.**, family practice; **Kathleen Ayaz, M.D.**, medicine; **Edward G. Hames, M.D.**, neurosciences; **Russell Wavrin, M.D.**, ob/gyn; **Gordon Aamoth, M.D.**, orthopedics; **Mark Arneson, M.D.**, pathology; **Jennine Speier, M.D.**, physical medicine and rehabilitation; **James Guerrero, M.D.**, psychiatry; and **John O'Leary**, surgery.

Sister Kenny Patient of the Year

Sister Kenny Institute has named **David Davenport** its Patient of the Year. Davenport was moved to the rehabilitation center, located at Abbott Northwestern Hospital in Minneapolis, after brain damage he suffered in a car accident. His family was told he would remain in a vegetative state for life, but after nine months in the Coma Assessment Program at Sister Kenny Institute, Davenport began to relearn how to move, read, and speak. Davenport is a former mayor of Plymouth, Minnesota, where he lives with his wife, Belle.

Professional Assessment Director

Abbott Northwestern Hospital's Behavioral Health Services has named **Kent Neff, M.D.**, medical director of its Professional Assessment Program, which is designed to provide an objective evaluation of professionals suspected of misconduct. Although it is focused primarily on physicians, the program will also aid clergy, attorneys, teachers, and other professionals. Neff has worked with licensing boards, hospitals, professional societies, and businesses for more than 20 years and has worked as a consultant with physician health programs.

Places

Reorganization at United

Over the next three years, United Hospital will be reorganizing its structure and reconstructing the hospital. Patients will be grouped according to their needs, closer to needed routine services like x-rays and lab work. The hospital will be reorganized around eight centers: the birth center, behavioral health, emergency, oncology, heart, lung, rehabilitation/ortho/neuro/epilepsy, and medical center. The hospital expects the reorganization to eliminate some management positions (without layoffs) and to speed decision making.

Wayzata Medical Center Addition

The Wayzata Medical Center began a $7 million, 49,675-square-foot expansion of its existing facility near Interstate 394 and North Highway 101. The construction includes a two-story addition and a new third floor on the current center. The expansion will enable the center to add increased diagnostic radiology capabilities, an on-site laboratory, community education classrooms, and an expanded rehabilitation facility, as well as provide space for old and new tenants. The center plans to place a strong emphasis on primary care and expand its ob/gyn, internal medicine, family practice, pediatrics, and rehabilitation services. The construction is expected to be completed by early 1995.

Blues Create Network Management Division

Blue Cross and Blue Shield of Minnesota has created a network management division to encompass all its provider network development and management activities, as well as new partnerships with providers throughout Minnesota.

Mark Banks, M.D., president and chief executive officer of the Blues HMO affiliate, Blue Plus, will lead the Network Management Division. Members of the new division will manage the company's development of regional integrated delivery systems, provide contracting strategies with the systems, develop other quality-based specialty networks, manage the

Blues Center for Health Services Research and Evaluation (which houses data collection and information management programs), and handle other case management, utilization review, and care management activities.

Arden Hills Clinic Opens

Arden Hills Family Physicians, a primary care medical clinic staffed by board-certified family practitioners, opened April 18 in Arden Hills. The clinic, a service of Fairview Health System, will offer comprehensive family care to those who live in the northeast suburbs. The staff includes Benson Leo, M.D., Joseph Ofstedal, M.D., and Loren Wilkes, M.D. Wilkes says the clinic will treat patients of all ages for acute and chronic illnesses, will provide health education and preventive care, and will offer maternity, childbirth, and newborn care. Doctors at the clinic will have staff privileges at Fairview Riverside Medical Center in Minneapolis.

Metropolitan Healthcare Council Awarded $100,000

The state of Minnesota awarded the Metropolitan Healthcare Council a $100,000 grant to implement the Minneapolis/St. Paul Health Care Youth Apprenticeship Demonstration, a project that prepares students for future careers. The three major components of the apprenticeship are work-based learning, school-based learning, and certification so students can begin their careers at an advanced skill stage. Johnson High School in St. Paul and Roosevelt High School in Minneapolis are the two demonstration sites for the program.

Socioeconomics

Methodist and Park Nicollet Merge Occupational Health Services

Methodist Hospital and Park Nicollet Medical Center have merged their occupational health services to form Occupational HealthSystem Minnesota (OHSM). The new organization will provide the following occupational health services to local employers: a workers' compensation managed care plan, occupational rehabilitation, drug screening, pre-placement examinations, onsite occupational health testing, physician and nursing adviser services, and health education programs.

The integration now enables OHSM to offer physician services supported by a specially trained nursing staff with extensive managed care experience. John Whisney, an OHSM administrator, says among the staff's priorities will be to return injured workers to the job as quickly as possible and to contain workers' compensation costs.

Mayo Clinic Signs Agreement With PreferredOne

Mayo Clinic has signed an agreement with PreferredOne that makes the clinic a participating provider in the Minneapolis-based managed care organization's preferred provider health care network. The collaboration will allow the 400,000 PreferredOne members more accessible and cost-effective care at the Mayo Clinic, as well as at Saint Marys and Rochester Methodist hospitals in Rochester. PreferredOne was established in 1984 as a joint venture of Twin Cities hospitals and physicians to provide health care services to its members through a network of more than 50 hospitals and 4,500 physicians.

HMO Council Questionnaire to Help Prevent Preterm Births

The Minnesota Council of HMOs has developed a questionnaire to help physicians identify pregnant women at risk for delivering preterm or low birthweight babies and to intervene. The form, developed with the state departments of Health and Human Services, asks mothers about their social service needs, such as transportation and counseling, and about their medical needs. The council tested the form on more than 800 women, mostly at initial obstetrical visits, at about a dozen clinics around the state. It expects the form will be in use statewide by early next year, said Medica spokesperson Ceil Boesche.

Five percent of Minnesota babies were born prematurely and 9 percent had low birthweight in 1991. The "Minnesota Healthy Pregnancy Outcome Assessment Form" will help providers intervene in high-risk pregnancies by asking such questions as whether the patient has enough money to meet basic needs, has a partner who can fill the role of a caring father, can easily get to health care appointments, or has been a victim of emotional or physical abuse. Providers will be trained to use the data to help determine whether intervention is appropriate and which services are needed. The HMOs and state officials are developing a statewide list of such resources.

Fairview Expanding to Wyoming, Affiliating with Chisago

Fairview Health System is planning to build a 28-bed hospital along Interstate 35 in Wyoming, just north of Forest Lake. Chisago Health Services has agreed to become a wholly owned subsidiary of Fairview's new system in the area, and District Memorial Hospital in Forest Lake is also negotiating with Fairview regarding affiliation.

"It certainly makes economic sense to operate only one hospital in the Forest Lake area," said Jack Lannon, administrator for District Memorial. "Our hospitals are 10 miles apart now. But we'd be only four miles apart if the new one gets built." Chisago Lakes and District Memorial hospitals are each licensed for 49 inpatient beds, but they never come close to being full.

Fairview will invest up to $22.9 million to remodel the existing hospital and clinic in Chisago City for primary and urgent care and to

build the new hospital in Wyoming, which will include hospital care, ambulatory care, and specialty services.

United HealthCare Selling DPS

United HealthCare Corp. is selling Diversified Pharmaceutical Services (DPS) to SmithKline Beecham Corp. for $2.3 billion in cash. Under the agreement, Minnetonka-based United will maintain some management control of DPS, will keep DPS operations in Minnesota, and will collect management fees tied to future sales. DPS, which has been one of United's most profitable and fastest-growing subsidiaries, helps clients control prescription drug costs and utilization through its research and volume purchasing programs. SmithKline had been looking for such a company to help it manage changes in the drug marketplace.

In other news about United HealthCare, it reported first quarter earnings for 1994 of $64.3 million, up 50 percent from the same quarter last year. Revenues were $713.4 million, a 23 percent increase over first quarter 1993.

Abbott Laying Off Nurse Anesthetists

In an effort to cut costs, Abbott Northwestern Hospital in Minneapolis is considering laying off nurse anesthetists and rehiring them on a contract basis. The approximately 50 nurse anesthetists at Abbott have traditionally worked on teams with physician anesthesiologists who are not employees but contract with the hospital. Under the proposed plan, nurse anesthetists would form their own company and contract with the physicians. The physician group in turn would contract with the hospital and continue to provide anesthesia services with a physician-nurse anesthetist team approach.

A hospital task force has agreed to investigate this option and to pursue details of the contracts. Officials said they are several months away from a final decision.

Carlson Vetoes Health Bill

Gov. Arne Carlson vetoed the $22 million health and human services bill, which included $8 million for subsidized care, $800,000 for nursing homes, and money to prevent a $13.8 million cut in payments to hospitals across the state. Carlson said that, although the bill contained a number of good proposals, it contained an unacceptable level of overspending.

Hospital officials predicted that the cuts might force some hospitals to close, particularly those with a high percentage of Medicaid patients. Gillette Children's Hospital in St. Paul and Minneapolis Children's could be in jeopardy. Gillette said it would lose 43 percent of its inpatient reimbursement if the bill was vetoed. Minneapolis Children's owes the state $5.2 million due to a recalculation in state reimbursements. If the health and human services bill had passed, part of that loan might have been forgiven, but now the hospital must come up with the entire amount. To save money, Minneapolis Children's may eventually have to lay off employees and cut back on patient programs, according to hospital officials.

Sen. Kennedy Proposes Own Health Care Bill

Sen. Edward Kennedy proposed in early May a health system reform bill that would exempt the smallest, lowest-paying companies from the employer mandate portion of President Clinton's reform proposal. His draft bill also would eliminate Clinton's compulsory health purchasing alliances.

As *Minnesota Medicine* goes to press, the five congressional committees with jurisdiction over health care were attempting to produce a bill by Memorial Day. Kennedy planned to propose his bill to the Labor and Human Resources Committee, which he chairs.

Specifically, Kennedy's bill would exempt companies employing fewer than five workers all of whom make an average of less than $24,000 a year, or about 5.5 percent of the work force. Companies that do not pay for benefits would instead pay a 2 percent payroll tax. His bill also would require workers in small companies that do not provide coverage to buy their own, sometimes with government-financed discounts, and it would make the government-run purchasing cooperatives, or health alliances, one of several options available to employees in companies employing more than 1,000 workers.

Rates, Trends, Data

Minnesota Healthiest State

Minnesota is the healthiest state in the nation, according to "Health Care State Rankings 1994" published by the company Morgan Quitno in Lawrence, Kansas. Following Minnesota were Vermont, New Hampshire, Nebraska, and Hawaii. Last year's top-ranked state, Utah, fell to sixth. The states with the worst health care rankings were Delaware, Missouri, Florida, Louisiana, and Arkansas.

The rankings are based on 23 statistical factors related to health, such as the percentage of adults who smoke or are overweight, the death rate from AIDS, the infant mortality rate, and the percentage of drivers who wear seat belts. Other factors included the number of community hospitals and the percentage of children entering kindergarten who were fully immunized.

A separate report released by Gov. Carlson and the Minnesota Planning Office announced that Minnesota also has one of the lowest unemployment rates, its economy is better than the nation as a whole, pollution and crime are declining, and more of the state's high school students go to college. The report, "A Cut Above: Minnesota's National Rankings," included rankings from a variety of federal agencies, private studies,

and magazine ratings. Minnesota consistently ranked in the top five or six states in several key areas. As for health care, it ranked second in the overall well-being of children and had the fewest residents not covered by health insurance; the state's children were ranked third-healthiest in the nation; and the state had the fourth-best birth-weight rate.

Americans Value Freedom of Choice in Health Care

Approximately three-fourths of Americans would rather pay more and be able to select their personal physician, get care right away, and use a particular hospital, than pay less and have less flexibility. The proportion willing to pay more to choose their own physicians increased from 76 percent in 1993 to 81 percent this year. The findings come from the American Medical Association's 1994 survey, "Public Opinion on Health Care Issues," conducted by the Gallup Organization.

Fifty-seven percent would rather pay more out of pocket to private doctors and hospitals than pay higher taxes and have the government be in charge of health care delivery. Support for a private system increased by 8 percentage points from 1993 to 1994. Public support for government-controlled health care organization and delivery decreased from 46 percent in 1993 to 39 percent in 1994, according to the survey.

The survey also revealed that 83 percent of Americans have health insurance, a five-percentage point decrease from 1991. The large majority—93 percent—were either very or somewhat satisfied with the medical care they received on their last medical visit; 96 percent were very or somewhat satisfied with how doctors' staffs treated them; 91 percent with the way doctors explained things; 86 percent with the amount of time they had to wait to get an appointment; and 81 percent with the time they had to wait before seeing the doctor.

Law & Policy

Woman Gets 11 Years for Shooting Doctor

Rachelle "Shelley" Shannon, an anti-abortion activist who admitted to shooting an abortion doctor outside his clinic in Kansas, was sentenced to nearly 11 years in prison. George Tiller, M.D., was shot in both arms as he left his clinic August 19. The injury was minor, and he returned to work the next day.

The 38-year-old Shannon, of Grants Pass, Oregon, told the judge at her sentencing hearing that attacking Tiller wasn't wrong. "It would be hypocritical to pretend like I feel I did something wrong when I know I didn't," she said.

Shannon was also convicted of aggravated assault for pointing a gun at a clinic employee and was found in contempt for refusing to say where she got the gun. She received a nine-year, eight-month prison sentence on the attempted murder and aggravated assault charges, which is the maximum time recommended under Kansas guidelines, and a one-year jail sentence for the contempt charge. State and federal authorities in several jurisdictions are investigating her possible links to violence against other abortion clinics.

AIDS Update

AIDS Increasing Child Mortality

After years of improvement, childhood survival rates in Third World nations are falling due to infant and childhood deaths from AIDS, reports the Census Bureau. Projections on AIDS in 13 sub-Saharan countries, Brazil, Thailand, and Haiti show that without a drastic decrease in AIDS infections, the childhood mortality rates for these countries will triple by the year 2010. For example, bureau demographers estimated that 209 of every 1,000 children would die in Malawi in the year 2010 from AIDS, compared with estimates of 136 deaths without the disease. MM

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JUNE 1994

June 8-10 **American Society for Bariatric Surgery** University of Minnesota; Minneapolis Hilton, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 15-17 **Topics and Advances in Pediatrics** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 15-18 **Fifty-eighth Annual Surgery Course: Advances in Hepatic, Biliary, and Pancreatic Surgery** University of Minnesota; Willey Hall at University of Minnesota, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 17-18 **Mayo Ophthalmic Reviews** Mayo Clinic, Department of Ophthalmology; Mayo Medical Center, Rochester, MN. CONTACT: Darcie Skoda, Department of Ophthalmology, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; 507/284-1709.

June 20-24 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.

June 24-25 **Critical Care Conference** University of Minnesota; Mall of America Grand Hotel, Bloomington, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 24-26 **Bone and Soft Tissue Review Course** University of Minnesota; Location to be announced. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, #107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 27-July 1 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.

JULY 1994

July 7-9 **Chronic Lymphocytic Leukemia** Mayo Medical Laboratories; Silverado Country Club and Resort, Napa, CA. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

July 11-15 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.

July 14-15 **Advanced Pediatric Life Support** Hennepin County Medical Center; Hennepin County Medical Center, Minneapolis, MN. CONTACT: Rachel Knudson, R.N., EMS Training, Hennepin County Medical Center, 701 Park Avenue South, Minneapolis, MN 55415; 612/347-3638.

July 15-16 **Gynecologic Cytology** Mayo Medical Laboratories; Harold W. Siebens Building, Rochester, MN. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

July 22-24 **The Challenge of Spine Care Management** Minnesota Spine Center; Arrowwood Resort, Alexandria, MN. CONTACT: Beth Cant, Minnesota Spine Center, 606-24th Avenue South, Suite 606, Minneapolis, MN 55454; 612/672-6685.

July 25-29 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.

July 25-29 **•Malpractice Prevention in Mental Health •Effective Organizational Consultation: Developing the Necessary Skills • The Essentials of Brief Psychotherapy for Families, Couples, and Individuals** Psychotherapy Center at Columbia Hospital and the Department of Psychiatry at the Medical College of Wisconsin; Egg Harbor, WI. CONTACT: Carlyle H. Chan, M.D., Summer Institute Director, Psychiatry Department, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, WI 53226; 414/257-5995.

AUGUST 1994

Aug. 1-5 **Psychotherapeutic Strategies with Borderline Patients • Treating Survivors of Incest and Abuse • Advance Topics in Neuropsychological Assessment and Treatment** Psychotherapy Center at Columbia Hospital and the Department of Psychiatry at the Medical College of Wisconsin; Egg Harbor, WI. CONTACT: Carlyle H. Chan, M.D., Summer Institute Director, Psychiatry Department, Medical College of Wisconsin, 8701 Watertown Plank Road,

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Aug. 4-7 **Annual Scientific Conference of the Philippine Minnesotan Medical Association** HCMC/HFA Office of Academic Affairs/U of M; The Breezy Point Resort, Breezy Point, MN. CONTACT: Ann Samways, CME Coordinator, 612/347-2078, or Robin Hoppenrath, Manager, Office of Academic Affairs, 612/337-7128.

Aug. 5-6 **Bleeding and Thrombosing Diseases** Mayo Medical Laboratories; Harold W. Siebens Building, Rochester, MN. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Aug. 8-12 **Psychopharmacology Consultations • AIDS/HIV Prevention, Therapy, and Mental Health Consultation Issues** Psychotherapy Center at Columbia Hospital and the Department of Psychiatry at the Medical College of Wisconsin; Egg Harbor, WI. CONTACT: Carlyle H. Chan, M.D., Summer Institute Director, Psychiatry Department, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, WI 53226; 414/257-5995.

Aug. 22-Sept. 2 **Twelfth Annual Occupational Health and Safety Institute** St. Paul-Ramsey Medical Center; University of Minnesota, Mayo Building, Minneapolis, MN. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

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Physician Opportunities and Miscellaneous Listings

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General Surgeon, Ob/Gyn, Internal Medicine to join progressive 13-physician group practice. Rural college town 30 miles from St. Paul, Minnesota. New clinic and new hospital. Contact: Robert B. Johnson, M.D., River Falls, WI 54022; 715/425-6701. (*5/94-R)

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Family Physicians, P.A., 612/835-3609, or send inquiries to 7801 East Bush Lake Road, Suite 400, Bloomington, MN 55439. (*3/93-R)

Mankato Clinic, Ltd. is seeking additional BC/BE physicians in the following specialties: orthopedics, radiology, invasive cardiology, oncology/hematology, family practice, and general internal medicine. The Mankato Clinic is a 59-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. M. P. Wheeler, President, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (10/93-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

BC/BE Internal Medicine and Ob/Gyn Physician: Excellent opportunity to join a well-established, progressive, 26-physician multispecialty group located in an economically sound community of 22,000 (drawing area of 45,000), 65 miles south of the Twin Cities. Full membership after one year. Competitive salary and fringe benefits package. Contact Craig Oien, M.D., or Terry Tone, Administrator, 134 Southview, Owatonna, MN 55060; 507/451-1120. (9/92-R)

Forest Lake Doctor's Clinic is seeking a BC/BE family physician and ob/gyn to join a growing 12-physician multispecialty practice. Located 25 miles north of Twin Cities in progressive community with excellent schools, outstanding recreational activities. Hospital located across street from clinic. Respond with CV or call Doug Sill, M.D., Harvey Frank, M.D., or Geoff LaGary, Administrator, 121 SE 11th Avenue, Forest Lake, MN 55025; 612/464-7100. (11/92-R)

Olmsted Medical Group is seeking BC/BE physicians in the following specialties: orthopedics, radiology, family practice, emergency medicine, and ob/gyn. Great opportunity for well-trained physicians to join a 55+ physician multispecialty group in a dynamic, progressive practice. In addition to the main office in Rochester, the group operates eight branch offices in southeastern Minnesota. Excellent salary/benefits package includes malpractice insurance, flexible benefits plan, 401(k) and profit sharing, and relocation assistance. Send CV to Olmsted Medical Group, Attn: Susan Schuett, 210 Ninth Street SE, Rochester, MN 55904. (1/92-R)

Internal Medicine and Dermatology practice opportunities available at the Faribault Clinic. The Faribault Clinic is a multispecialty group practice of 18 physicians. Faribault is located 50 miles south of Minneapolis on I-35. For more information contact Ray W. Wood, M.D., or Ken Smith, Administrator, 924 NE First Street, Faribault, MN 55021; 507/334-3921. (4/94-R)

Stillwater: 20-physician multispecialty group with emphasis on primary care seeking BC/BE family physician. Scenic location with excellent school system, supportive medical community with strong local hospital, competitive salary and benefits. Send CV to Jon Pedersen, St. Croix Valley Clinic, 921 South Greeley, Stillwater, MN 55082; 612/439-2215. (9/93-R)

Family Physician wanted to join six-physician, three-P.A., two-site family practice group in St. Anthony and Shoreview. Obstetrics available. Competitive salary, benefits package, and call schedule. Contact Gerald Pitzl, M.D., Silver Lake Clinic PA, 612/788-9251. (7/91-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

General Surgeon Bc/Be

The Department of Surgery at the Mayo Clinic in conjunction with the Decorah Clinic is seeking a broad-based general surgeon to join the Mayo Regional Facility in Decorah, Iowa, 70 miles south of Rochester, Minnesota.

This position offers an excellent opportunity to establish a surgical practice in an established 9-person, Mayo-affiliated medical clinic in this town of about 8,100 with a 60-bed hospital and a county population of 26,000.

This opportunity allows practice autonomy, a wide spectrum of general surgery, including some gynecological and orthopedic expertise, and excellent salary and benefits. Inquiries:

Michael G. Sarr, M.D.
Department of Surgery
Mayo Clinic
Rochester, MN 55905

Mayo Foundation is an affirmative action and equal opportunity educator and employer.

Family Practice, Surgeon: Five family practice group seeks surgeon, plus one or two family practice physicians. Population 8,000. One hour south of Burnsville Center. Lakes, industry, negotiable salary. Clinic adjacent to hospital. Ample free time to enjoy family life. Contact James W. Dey, M.D., or Ruth Hawker, Clinic Manager, 501 North State Street, Waseca, MN 56093; 507/835-3110. (9/93-R)

Mora, Minnesota: Aggressive, young, seven-physician family practice group seeks to add one or two physicians. Mora is a friendly community located one hour north of Minneapolis/St. Paul. There is abundant outdoor recreation in the area, including Mille Lacs Lake. The town is host to the Vasaloppet Ski Race, a half-marathon, canoe race, and bike race. If you are interested in this practice opportunity, and you should be, please contact Peter J. Donner, M.D., Mora Medical Center, Ltd., Mora, MN 55051; 612/679-1318 (wk); 612/679-1981 (hm). (11/92-R)

Urgent Care Physicians: Immediate part/full-time positions available at two Convenience Care centers in northwest suburbs of the Twin Cities. Family practice trained providers sought. Excellent opportunity for those physicians seeking freedom from call and hospital responsibilities. Patient base is primarily young adults and children. Attractive hours and compensation. Send inquiries to Robert Kantor, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

College Health Physician:

Student Health Services at Mankato State University seeks a physician to provide outpatient medical care for diverse student population in a comprehensive outpatient center that offers general medical care, laboratory and x-ray services to adolescent and adult students. Health education is a major focus. BC, preferably family practice or internal medicine. Minnesota license eligible. Academic year (nine-month) appointment plus one five-week summer session. No evening or weekend call. Excellent benefits.

Send application letter, CV, and names, addresses, and phone numbers of three references to Donald H. Craig, Ph.D., Director of Counseling and Health Services, PO Box 8400, MSU #21, Mankato, MN 56002; 507/389-6276. MSU, a comprehensive university of 13,000 students located 80 miles south of Minneapolis/St. Paul, is actively seeking faculty and staff that will enrich its cultural, racial, and ethnic communities.

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Internal Medicine—Twin Cities/Northwestern Suburbs: Busy, young, four-physician practice. Excellent salary and benefits for the right BC/BE physicians interested in all aspects of internal medicine. Growing hospital and clinic practice expanding to new site. No management duties or buy-in required. Send CV/call Lex Nerenberg, M.D., Bass Lake Physicians, PO Box 29188, Minneapolis, MN 55429; 612/537-6022. (3/93-R)

Mankato, Minnesota: FP needed to join group of five board-certified family physicians aged 36 to 46 in fast-growing, full-range practice. Ob optional. Population approximately 40,000. Seventy miles to Twin Cities. Five colleges nearby. Subspecialty consultation readily available on hospital staff. Academic appointment available. Call Gregory Kutcher, M.D., or Linda Dulas, Clinic Manager, 1695 LorRay Drive, North Mankato, MN 56003; 507/387-8231. (*4/94-R)

Family Physician: Tired of call? Want predictable hours? Full-time physician needed to work three days per week in our ambulatory care centers located in Roseville, Minnetonka, and Eagan. Salary $80,000 minimum and benefits package including malpractice insurance. Also, looking for part-time physicians to cover for Sundays and vacations. Contact Cara Auge or William Wenmark, c/o NOW Care Medical Centers, 13031 Ridgedale Drive, Minneapolis, MN 55305; 612/593-9010. (10/93-R)

Pediatrician—BC/BE: Premier pediatric group in affluent suburbs of Twin Cities has unusual opportunity for new members. Fringe benefits and compensation well above average. Contact: Sally Vissers, Metropolitan Pediatric Specialists, P.A., 6545 France Avenue South, Suite 510, Edina, MN 55435-2186; 612/920-9191. 3-7/94

Family Practice, General Surgeon, Emergency Medicine, Internal Medicine, Locums, Ob/Gyn, Occupational Medicine, Pediatrics, Urgent Care opportunities available in Minneapolis/St. Paul and leading communities within a 150-mile radius of the Twin Cities. Contact HealthSpan, Physician Services, 2810 57th Avenue North, Minneapolis, MN 55430; 800/248-4921 or 612/574-7627. *1-6/94

Eugene, Oregon: 53-physician multispecialty group is seeking BC/BE family physician. Practice includes ob. Excellent schools. Abundant cultural and recreational opportunities. Near Cascade mountains and coast. Home of University of Oregon. Please send CV to James Schwering, Administrator, Oregon Medical Group, PO Box 1648, Eugene, OR 97440. *3-6/94

Family Practice Physician needed to join established group of five FPs and one pediatrician in northwestern Wisconsin community of 8,000 with service area of 40,000—located on the doorstep of Wisconsin's fabulous lake country. Practice medicine in a small, family-oriented community within two hours of Minneapolis/St. Paul. Competitive salary and excellent fringe benefits. Send CV to James Volk, M.D., Medical Director, PO Box 3217, Eau Claire, WI 54702-3217; 715/836-8552. *3-6/94

Wisconsin: 20-physician primary care group is seeking fourth BC/BE internist. Practice the full spectrum of internal medicine. City of 60,000 in west central Wisconsin, 90 miles from Minneapolis/St. Paul. Competitive salary and excellent fringe package. Contact James Volk, M.D., Medical Director, Group Health Cooperative, PO Box 3217, Eau Claire, WI 54702-3217; 715/836-8552. *3-6/94

Wisconsin—Family Practitioner Needed by progressive and growing group practice in west-central Wisconsin city of 60,000. Ninety miles from Minneapolis/St. Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high-quality care in a good recreational area. Send CV to James A. Volk, M.D., Medical Director, PO Box 3217, Eau Claire, WI 54702-3217; 715/836-8552. *3-6/94

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For more information, contact:

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itan practice style, 25 miles from Minneapolis. Group has excellent reputation and large geographical referral area. Recently expanded facility is adjacent to newly remodeled 110-bed hospital. Comprehensive benefits package with excellent remuneration. Interested surgeons should contact Donald E. Somers, M.D., Lakeview Clinic, Ltd., 424 State Highway 5 West, Waconia, MN 55387; 612/442-4461. AA/EOE. 3-6/94

Full-time Family Physician for outpatient family practice clinic. No obstetrics, ER, or hospital responsibilities. Very progressive north lakes practice located in Pine River, Minnesota. Competitive salary. Send CV or call Carolyn Bridge, Pine and Lakes Clinics, PO Box 88, Pine River, MN 56474; 218/587-4416. 2-6/94

Practical Strategies in the Evaluation and Management of the Geriatric Patient: September 8-9, 1994; Holiday Inn Homestead, U.S. Highway 51, Minocqua, Wisconsin. Contact Marshfield Clinic, Office of Medical Education, 1000 North Oak Avenue, Marshfield, WI 54449; 800/541-2895. 2-7/94

Internal Medicine—Minneapolis: BC/BE general internists needed to join the Department of General Internal Medicine of a 376-physician multispecialty clinic in desirable Twin Cities area. Currently, we have positions available at our Burnsville and Shakopee offices. These are traditional practices with both ambulatory and hospital components. Sal-

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ary and benefits are highly competitive. For additional information contact Patrick Moylan, or send CV and letters of inquiry to Physician Recruitment, Park Nicollet Medical Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3286. Fax: 612/924-2819. *2-7/94

General Practitioner: Immediate opening in Minneapolis suburb. Competitive guaranteed salary. Corporate full fringe benefits. Call medical director, 612/572-1250, or send CV to Heights Medical Clinic, 4555 University Avenue NE, Columbia Heights, MN 55421. 2-7/94

Alexandria, Minnesota: Runestone Family Practice, P.A., is seeking a family practice physician. Alexandria is located off I-94 in the lakes region of central Minnesota. It has a stable economy and a modern, progressive hospital. Many medical specialties are represented in the community. We are offering a competitive salary and benefits package. For more details, contact Runestone Family Practice, P.A., at 612/762-1146. 7-12/94

Orthopedic Surgery—West Central Minnesota: 90+ physician multispecialty group is currently looking for two BC/BE orthopedic surgeons to join a busy three-person orthopedic department. A large 55+ physician primary care department ensures an active and interesting practice. Affiliated Medical Centers, headquartered in Willmar, Minnesota, serves a population of more than 220,000 from eight locations in west-central Minnesota. Organization offers an attractive and competitive salary and benefits package. Contact John P. Merickel, M.D., Recruitment Director, Affiliated Medical Centers, P.A., 101 Willmar Avenue SW, Willmar, MN 56301-3591; 612/231-5050. 2-6/94

Wisconsin—Third BC/BE Obstetrician/Gynecologist needed to join stable, progressive, primary-care-based HMO/group practice in university town of 60,000 near Minneapolis/St. Paul. Excellent quality of life and outstanding recreational area. Competitive salary and fringe benefits. Contact: Medical Director, Group Health Cooperative, PO Box 3217, Eau Claire, WI 54702-3217; 715/836-8552. *3-7/94

Family Practice—Minneapolis, Minnesota: Suburban practice, 15 minutes from downtown. Multispecialty group with 25 family practice physicians has an excellent opportunity available. Call one weekday a month and one of four weekends (one day), full day off during week, excellent compensation and unparalleled benefits program. Call Tom Behrend, 612/586-5882, or write Columbia Park Medical Group, 6401 University Avenue NE, Suite 200, Fridley, MN 55432. 3-8/94

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- *INTERNAL MEDICINE*
- *OBSTETRICS & GYNECOLOGY*
- *FAMILY PRACTICE*
- *PEDIATRICS*

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Timothy A. Hunt, Administrator
Alexandria Clinic, P.A.
610 Fillmore Street
Alexandria, MN 56308
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in this 17-member department of physician-owned clinic with its own HMO. Professional administration enables physicians to concentrate on the practice of medicine. Outstanding lifestyle, excellent income guarantee, complete benefits, and ownership eligibility. Call or send CV to Denis Albright, Medical Associates Clinic, 1000 Langworthy, Dubuque, IA 52001; 800/648-6868. *3-8/94

Family Practice Opportunity: Minnesota's North Shore offers a unique lifestyle and an opportunity to work in well-established, growing, community clinic. Board certified family practitioner needed to complete physician group. Student loan repayment program, competitive compensation, benefits package. Services include low-risk obstetrics and ER coverage. Flexible hours. Hospital/nursing home locally. Contact Rita Plourde, Executive Director, Cook County Community Clinic, Grand Marais, MN 55604; 218/387-2330. 3-7/94

Family Practice, Internal Medicine Physicians: Excellent private practice and urgent care opportunities are available in beautiful south-central and southeastern Wisconsin. Extremely competitive compensation packages. For information, send CV to P.J. Murphy & Associates, Inc., 735 North Water Street, Suite 915, Milwaukee, WI 53202; or call collect, 414/277-9777. 1-6/94

Family Practice Opportunities: Cook Area Health Services, located in the beautiful north woods of Minnesota near Lake Vermilion, has immediate openings for BC/BE family practitioners for its sites in Cook, Bigfork, and Northome. Enjoy the challenges and rewards of busy, well-established rural practices near Superior National Forest and the Boundary Waters Canoe Area. Excellent compensation and full benefits package, including paid malpractice, tax sheltered annuity, and generous vacation and CME. Loan repayment available. Contact Rhonda Degelau, Minnesota Primary Care Association, 1315 East 24th Street, Minneapolis, MN 55404; 612/721-0003. 2-7/94

Whitefish Lake Retreat: All amenities on best "chain of lakes" in Minnesota, minutes from Brainerd. Perfect for two (or three) couples to share (three master bedrooms with private bath). Five bedrooms, four baths, living room with field-stone fireplace, dining room, kitchen, screen porch, front deck, front and rear patio, hiking trails (on/off beach) in shared 300-acre preserve with tennis court. Includes use of canoe, 14-foot Alumicraft fishing boat, and "Sailfish" sailboat. Excellent swimming beach. Treat your family (and yourself) to the ultimate lake experience. $2,100 per week. 612/227-6301. *1-6/94

Occupational Medicine Specialist, BC/BE, FT, to join established group of eight physicians providing care for diverse employer-client base in St. Paul and Eagan, Minnesota. Excellent communication skills, strong commitment to patient care with MRO and IME experience. Competitive earnings and benefits. Contact: Debbie Modder, HealthSpan, 2810 57th Avenue North, Minneapolis, MN 55430; 800/248-4921 or 612/574-8803. 2-7/94

NEW ADVERTISING RATES

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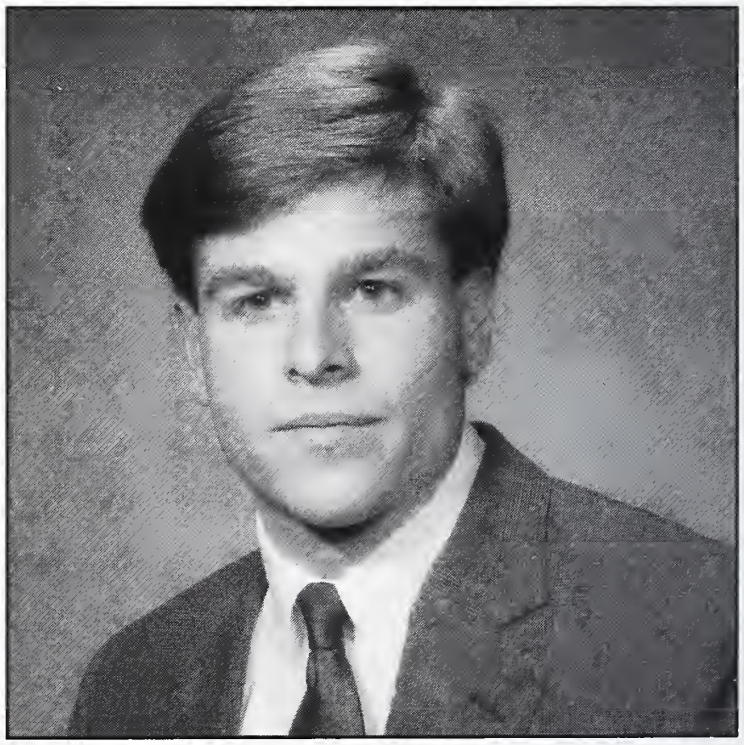

Scott Steil
Duluth, Minnesota

Minnesota Medicine

Published monthly by the Minnesota Medical Association

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Illustration by Tom Rosborough.

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Understanding a Changing Environment

Your April Perspectives article, "Visions and Missions Improving Medicine—NOT!" by Seymour Handler, M.D., seems to reflect a reactionary's view of the changing health care environment. In his opening paragraphs, Dr. Handler recognizes, but then complains about, the evolutionary nature of language. What the author appears to misunderstand is the need for members of any community, whether an age group, a profession, an industry, or society at large, to use an evolving language responsive to changes in their environment. Commonly understood terms are essential to accurate communication within and between segments of a community. Failure to understand new terminology, or personal aversion to its use, is not a valid argument to justify resisting changes in terminology that respond to a changing environment.

Dr. Handler seems to forget that the medical profession is not different in this need to communicate. Medical terminology continuously evolves in response to new developments in technology and other changes in the delivery of health care. CME, a term and concept that Dr. Handler knows well, was unknown not so long ago. Until recently, there were no CTs or MRIs, no angioplasty or laparoscopic surgery.

I do agree, in part, with his comment that "practicing physicians are no longer doctors; we are providers." In the practice of medicine, I am a physician, and the individual I care for is my patient. However, physicians collectively "provide" medical care and, whether we like it or not, our individual patients, collectively, are our customers.

Dr. Handler also misses the point regarding total quality management (TQM) and continuous quality improvement (CQI). Any informed person knows the medical profession has always expected its members to improve the quality of care delivered. A problem, or in CQI terms, "an opportunity for improvement," exists because of the relatively disorganized approach our profession, along with other health care providers, has taken to improve quality. Physicians are expected to continuously learn by reading and attending conferences. However, as a profession, we often fail to disseminate or apply important new knowledge in a timely, systematic manner. Members of this medical community may recall that, years ago, practitioners discontinued the routine practice of chest x-rays on admission in response to articles in the medical literature. I recently spoke with an HMO medical director who encountered a practice that did routine admission chest x-rays as recently as 1990.

A few comments about missions and visions: Until recently, most health care organizations, whether hospitals or clinics, failed to formally recognize their mission or describe their vision. A mission defines what we do; a vision describes what we want to become. Perhaps a couple of examples from other industries will help clarify the importance of missions and visions. At one time, Xerox was a manufacturer of copying machines. As Xerox developed its mission and vision in the context of its business environment, a thoughtful process led Xerox to redefine itself as an information management company. In another industry, a railroad company became a transportation company.

Changing or defining the way an organization views itself helps organize activities to fulfill its mission and achieve its vision. After all, you can't begin a journey if you don't know where you're going.

Perhaps the real issue for Dr. Handler and others is the fact that most of these terms originated outside our profession. It is much easier to take exception to someone else's language and easier to accept something we feel we "own."

Dr. Handler doubts these new terms improve medicine. He's right in that words alone accomplish nothing. However, those able to move beyond the words to the meanings will be able to participate in the restructuring of the health care system. Only with physician participation will the new system meet our needs and, more importantly, those of our patients.

Paul R. Hamann, M.D., M.S.
Past Vice-President, Medical Affairs
North Memorial Medical Center
Consulting Physician
Minnesota Lung Center
Minneapolis, Minnesota

Separate Lanes Not a Solution to Bicycle Collisions

As an avid cyclist, I read with interest the article in the April issue of *Minnesota Medicine* titled, "Bicycle-Motor Vehicle Collisions: Epidemiology of Related Injury Incidence and Consequences." The study seems to reaffirm most of the statistics from large, national studies. I applaud the study and all the conclusions—except one. It's debatable whether the increased availability and construction of separate bicycle lanes is a useful strategy. Per mile traveled, accidents are more likely on a bicycle trail than on any other type of transportation system. While these accidents are generally not quite as severe for the cyclist, they can be quite severe for the pedestrians involved in them.

Perhaps more important, this solution begs off the real issue—that many bicyclists don't know how to behave on a highway, and many motorists don't know how to behave around cyclists. Cyclists are supposed to drive their bicycle using the same rules as motor vehicles; this makes them predictable for the motorists. Motorists are supposed to treat bicyclists like any other vehicle on the road; this makes the motorists predictable for the bicyclists. When the two groups follow the same rules and give each other the proper respect on the road, most accidents don't happen. As an example, Denmark is a nation that has integrated bicycles and motor vehicles onto the same roadways quite well.

The method to decrease bicycle-motor vehicle collisions is not to remove the bicyclists from the roadway, but rather to properly educate both cyclists and motorists how to behave around one another. The means to accomplish this already exist. We have mandatory driver's education for motorists, and most communities offer bicycle safety courses for children. Added support and funding for these systems should be a goal.

Glenn Nemec, M.D.
Family Physician
Hart Medical Clinic
Monticello, Minnesota

Health System Reform Must Address Medicare Problems

This past April, the Minnesota Nurses Association and President Clinton had a meeting on health care. As usual at such meetings, they dodged the impact of the Medicare program.

I have a government report that says Medicare paid out $142.9 billion in fiscal 1993. That's an increase of 10.6 percent over 1992. Such numbers show that Congress cannot ignore the Medicare program.

I and my colleagues have a simple way of evaluating every health care reform proposal: We ask, "Does it absorb the Medicare program?" If not, it is instantly suspect, and we equate its effectiveness with rearranging the deck chairs on the Titanic.

Medicare is national health insurance for senior citizens. It is a useful program, but it has always been missing important aspects. Three examples are 1) it pays less than 80 percent of the cost of surgery; 2) it skimps on convalescent care; and 3) it does not pay for prescriptions.

Will Congress fix Medicare? Certainly, it cannot dodge this issue indefinitely. It must consider not only the cost, but also the number of people—some 32 million senior citizens are enrolled in Medicare.

About 40 percent of senior citizens have supplemental insurance paid by former employers. The remaining 19 million seniors are forced to pay out of pocket the costs Medicare won't cover. This is a serious drain on fixed retirement incomes.

We must address the problems of Medicare. I believe the best solution is a health care payment system that includes all Americans—that does not leave senior citizens standing on the side under a separate program.

Norin Elfton
The Gray Panthers
Lakewood, Colorado

Clarification

The June *Minnesota Medicine* article "Physician Prescribing Practices: Rx for Potential Pitfalls" inaccurately portrayed a number of drugs. An inadvertent copy editing error altered the sense of a statement that, as published, implied that Prozac, Prednisone, and anti-inflammatories are abused and addicting medications. The author's original wording describes these drugs as having the common problems of prolonged use and treatment of subjective symptoms. Although the author confirms that Prozac has been the focus of some Board of Medical Practice investigations, the implication that Prozac or these other medications are psychologically or physiologically addicting is erroneous. We apologize for the error.

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A Firm Foundation for Rural Health

Charles R. Meyer, M.D.

"I have never had a money practice; it would have been impossible for me. But the actual calling on people, at all times and under all conditions, the coming to grips with the intimate conditions of their lives, when they were being born, when they were dying, watching them die, watching them get well when they were ill, has always absorbed me."

–William Carlos Williams

"If what we build for health care in rural America intrudes into the exam room, we may lose even more of our rural physicians."

Total absorption has always been my vision of rural medical practice. Although Rutherford, New Jersey, in the early 20th century may not have mirrored rural Minnesota, a small-town feel jumps out of the pages of poet/physician William Carlos Williams' autobiography—the long hours, the house calls, the intimate knowledge of patients and their families. Has rural practice changed since Williams' time? How is it responding to Clinton, competition, and capitation? This issue contains four articles that show Minnesota's pastoral practices charging ahead toward the 21st century with innovation. Like all change, it is not without dyspepsia.

Rural medicine's woes are daunting, as detailed in the first few pages of the article by Kristen Gloege (page 23). Compared with urban residents, Minnesota's rural population is older, poorer, underinsured, undersupplied with doctors, and relies on hospitals tottering between life and death. Small-town Minnesota has a continuous doctor drought with only transitory relief; the physicians who come usually don't stay long. Edwin Anderson, et al. (page 29) saw these chronic physician shortages and appalling turnover rates and asked why rural docs practice where they practice. The answers are partners and place: Doctors looking at rural practice want competent colleagues. They want a comfortable community for spouse and family. They want the recreational advantages of rural areas. Unfortunately, the article only briefly touches on "exit interviews." What drives physicians away from Minnesota's forests and farm country on average every two years? What will entice more of them to stay in the future?

All our articles suggest that well-constructed organizations will provide the substrate for a growing rural physician population. Gloege describes a cooperative community health service planning initiative that plunges the entire community into building the health delivery system. In this month's Face to Face profile (page 6), Dr. Ray Christensen recounts the formation of a successful rural managed care program in 1985, when Hillary was more interested in futures than family practice. He touts physician collaboration for market power and sharing risk and declares, "It works." This month's feature article (page 10) describes two rural health networks, in Willmar and Owatonna, formed to answer the demands of consumer, business, and, now, state government. These meldings are intended to let rural practitioners play in the majors with HMOs, CISNs, and self-insured businesses. They are classic Minnesota solutions—building new organizations through cooperation and consolidation in a state with a strong history of group practice and a collegial approach to solving problems.

Just because we build new edifices, however, doesn't necessarily mean anybody wants to use them or that they can withstand wind and rain. "Clinics without walls" may work better as an urban "building" than a rural structure. The utility of CISNs as devised by the Legislature this year is far from proven. And the people who work and shop in these "buildings" have to feel comfortable, knowing that this is home-built stuff, not imported by outsiders who think they know what is needed. In addition to being cost- and energy-efficient, these "buildings" need to serve their doctor tenants and their patient customers.

Ultimately, it does return to Rutherford and my favorite poet. If what we build for health care in rural America, regardless of how good its organizational face, intrudes into the exam room, we may lose more of our rural physicians. Neither smoothly running communities nor ravenous trout will draw doctors to outstate Minnesota if the physician-patient chemistry is tainted. And we may miss the opportunity to hear another future poet make word music out of his contacts with patients. MM

An Ambassador *for* Rural Reform

Dr. Ray Christensen's dedication to his patients goes beyond providing care; he's doing anything and everything he can to improve health care access and quality in rural Minnesota.

. . . . . .

By Susan Rodsjo

Raymond Christensen has been called a lone voice in rural Minnesota. While many outstate physicians fear managed care and health reform, Christensen, a family practitioner in Moose Lake, Minnesota, is actively promoting and bringing it about. Name any organization in the state dealing with rural health care, and you'll most likely find Christensen working in some capacity—medical director for the Minnesota Center for Rural Health, the rural physician representative on the Minnesota Health Care Commission, and a consultant to the Office of Rural Health at the Department of Health, for example. Each role is part of his overall effort to improve and maintain rural health care access and quality, which he considers the most crucial concerns for rural Minnesota.

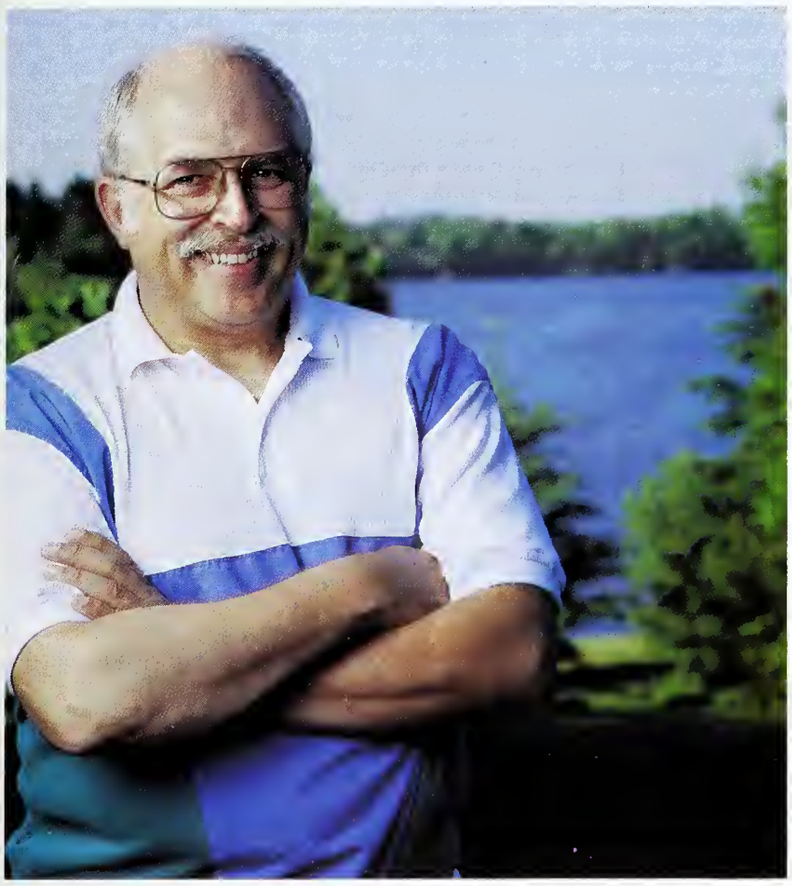
"Ray is truly driven to make a difference in health care," says Terry Hill, executive director of the Minnesota Center for Rural Health. "He's made a commitment to go beyond simply taking care of his patients—to help increase health care access in the state."

Christensen is a strong advocate of MinnesotaCare, which he believes will help increase health care access by allowing providers to collaborate. He also firmly supports the plan's call for managed care in rural Minnesota through the formation of community integrated service networks (CISNs). "Managed care in rural Minnesota encourages the maximum use of the health care dollar," says Christensen, who is also vice president of the MMA and immediate past president of the Minnesota Academy of Family Physicians. "It offers better continuity of care and appropriate, timely referrals to specialists. Patients are more likely to get the care they need."

Managed care is uncommon in rural Minnesota. In 1992, about 7.5 percent of the population in outstate Minnesota was enrolled in HMOs. This compares with about 43.5 percent in the seven-county metro area for the same year.

If anyone knows that managed care works in outstate Minnesota, it's Christensen. Moose Lake's Gateway Family Health Clinic, where Christensen practices, has used managed care since 1984, and in 1986 it formed the Northstar Physicians Plan with seven other clinics in the Duluth area to capitate and spread risk—"a clinic without walls, if you will," says Christensen. Northstar is a central organization that negotiates and contracts with HMOs on behalf of the clinics so that each receives the same capitation. Patients purchase insurance through Blue Plus and First Plan HMO, and the eight clinics share the financial risk. This primary care network has been so successful that it is looking at expanding to a primary care CISN as well as offering its network expertise to other groups.

"We've had a good experience with managed care," Christensen



PHOTOGRAPH BY BRUCE BAIRD

"My fight over the years has been to provide access to rural residents. I long ago learned that doesn't mean a doctor in every town."

–*Ray Christensen, M.D.*

says. "By coming together we have negotiating power, so we can sit down and talk to large organizations about putting together a plan that works for us. By working together and sharing the risk of financial loss, we have been able to do better than had any one of us offered the products alone. We feel Gateway is an important collegial network," he adds.

Yet Christensen understands the fear some physicians feel about the changes coming to rural Minnesota. When his clinic started negotiating with HMOs in the 1980s, he had his doubts. "I was a rural redneck back then and wasn't totally receptive to the concept. We had gotten burned hard a couple of times with HMOs."

Today, Christensen's enthusiasm for managed care is unmistakable. At the many health reform meetings he attends, he emphasizes that managed care can work in small-town America—in fact, he believes most rural doctors are already practicing it, whether they know it or not. "When I see a patient in rural Minnesota, I, by design, gatekeep. I am an access point. I can take care of 85, maybe even 90, percent of what comes through my door, but then I need to refer. I carefully choose the physicians to whom I refer, and that's managed care. All rural physicians do this. It will be hard for some to accept the term 'managed care,' but once they understand it, they will do OK."

That's not to say managed care won't alter rural medicine. Christensen expects the vertical relationships will be different. Physicians will practice in larger groups, and more clinics will use capitation, changing the way physicians are paid. And there will be more quality assurance, additional protocols and formularies to follow. "I think we should look at these things with an open mind. Managed care will bring improvements to practice as long as the controls are provided in a consensus fashion." In other words, he says, physicians must have input—they must be able to review and negotiate their contracts, referral relationships, protocols, etc. Then physicians will say, "Yes, this makes sense. I've had input, and it will work for me."

Of course, managed care is not the only reform necessary to improve health care in rural Minnesota. Christensen emphasizes that both physicians and rural residents need to change with the times and willingly look at new delivery systems. Residents need to realize that in the future, a physician may not be their primary caretaker—instead, it may be an allied health provider. And physicians should look at how they spend their time and possibly make more room for research, reading, education, and the practice of preventive medicine, he says.

Christensen adds that in many towns, hospitals will disappear. "We can't afford all the hospitals we have. To compensate, we must continue to improve

CHRISTENSEN continued on page 50

The Not-so-Implausible Tale of Dr. Ivar Hanson's Non-ISN

The law was clear: no ISN affiliation, no medical license. But Black Duck Lake's only doctor just wouldn't sign up...

BY S. HORATIO SLAWSON, M.D.

Ivar Hanson had practiced in Black Duck Lake, Minnesota, for 42 years. He was the only physician left in the state who had not registered with an integrated service network, or ISN, as they are known.

"His time is running out," my friend from the Department of Social and Health Services said, chuckling. We had been college roommates and he had gone on to study accounting, becoming a CPA. I had chosen medicine. We met occasionally for lunch.

I sat back, sipping my iced tea. "What happens next?"

"No ISN paperwork, no medical license. No medical license, no dollars for greedy doctors," he said.

"You think he's making a pile of money in Black Duck Lake?" I asked.

"He's the only doctor for miles around and has got to be making a killing; otherwise, why wouldn't he retire?" he responded.

I looked out the restaurant window and then back to my half-finished lunch. "There are other reasons," I said.

"I'm going up to Black Duck Lake this Friday, and I'll stay through Monday. By that time, I should have all the research I need on the good doctor," he said.

WE MET AGAIN FOR LUNCH several weeks later, and I hardly recognized him. While we waited to order lunch, he glanced at his watch nervously, looking out the window and toward the entrance, searching the faces of the patrons, hoping he would not be recognized. Gone was the air of supreme self-confidence I had envied. He had a furtive, hunted look. I was embarrassed for him.

"It was horrible," he said, beginning his story. "He must have known where I was going to stay because he picked me up as I arrived in town. He grabbed my luggage and put it in the back of his Ford, insisting that I stay at his place, and then drove me out—way out in the country—to his house beside the lake. I thought I had him," he concluded. His eyes gleamed for a moment with that old fire but quickly dulled again.

"THE HUGE CABIN WAS CUT and fashioned from the surrounding forest. He had cleared the land and built the cabin himself. Mrs. Hanson fixed dinner for us, chattering away the whole time. The next morning, she served me breakfast. She said she always rose early anyway to see the doctor off, and at 5:30 she knocked on my door, and I trundled down to a breakfast of oatmeal, fruit, bran nut muffins, and fresh blueberries with cream." My friend sank into a deep, painful silence for several minutes. Finally, he stirred himself, summoning strength, and began again.

"Everywhere I went in that town, every person I met told me the same thing. It was old Doc Hanson this, old Doc Hanson that. They all sang the same praises. 'Doc Hanson saved my mother when she had her appendicitis.' 'Ivar is the only one around here who can treat my asthma, my bronchitis, my arthritis, my leg swelling.' 'Did you hear that he found a tumor the size of an eraser tip down deep in Erma Peterson's breast,

ILLUSTRATION BY TOM ROSBOROUGH

saving her life from breast cancer? She's on the city council now, running for mayor.' "

My friend gazed out the window for a moment, then turning back to me, began once more.

"Some of his patients pay, some don't. I looked at the records in his office while he was out on a call. When they don't pay, he just puts a line through the entry. No collection agency, no repeat letters, no insistent phone calls. Just a line through the entry. The man's certifiable." Morosely, he nudged bits of chicken around on his plate.

"Dr. Hanson is well-connected, even without an ISN affiliation," he said with dismay. "He's still on the Clinical Associate Faculty at the University. Students come out to Black Duck Lake to learn family practice medicine. Over the years, he's had a hand in training internists, family practitioners, surgeons, and administrators. He knows everyone."

He paused for a moment. "My cousin lives in Black Duck Rapids, 10 miles away." He looked pale. I offered my water glass. Insistently, he shook his head no. "Our friend Ivar diagnosed an early endometrial cancer, called a former student down in Rochester, and my cousin had an operation two days later. He knows people at the University of Minnesota, Mayo Clinic, and in the huge hospital networks in the Twin Cities."

Our waitress took away his plate, the food untouched.

"I could have nailed him. He refused to fill out the forms for an ISN affiliation. 'A waste of time,' he said. No state bureaucracy would tell him how to run his practice, he said.

"I could have nailed him," my friend said, staring at the slice of berry pie on the plate in front of him. He pushed it away and resumed talking.

" 'It's no big deal, Dr. Hanson,' I told him. 'Just fill out the forms, sign them, send them in, and then continue with your practice, and if the patients need to be referred to a larger, specialized institution, you're all set.' He still refused."

AT THIS POINT, HE GLANCED ANXIOUSLY from side to side, ensuring that our conversation could not be overheard. He leaned forward, barely whispering. "He was going to lose his license. That town and all those people would have no doctor. I was stuck; I had to do what I did." He paused, leaning still closer to me. "I filled the forms out for him, not telling him, and I forged his signature."

He leaned back in his seat, with a deep sigh. I finished my last bite of pie, and gulped my coffee.

"You did the right thing," I said.

"I'm looking for another job," he said. "Something less stressful, like income tax work." MM

Horatio Slawson is a clinical instructor in the Department of Radiology at the University of Minnesota Medical School.

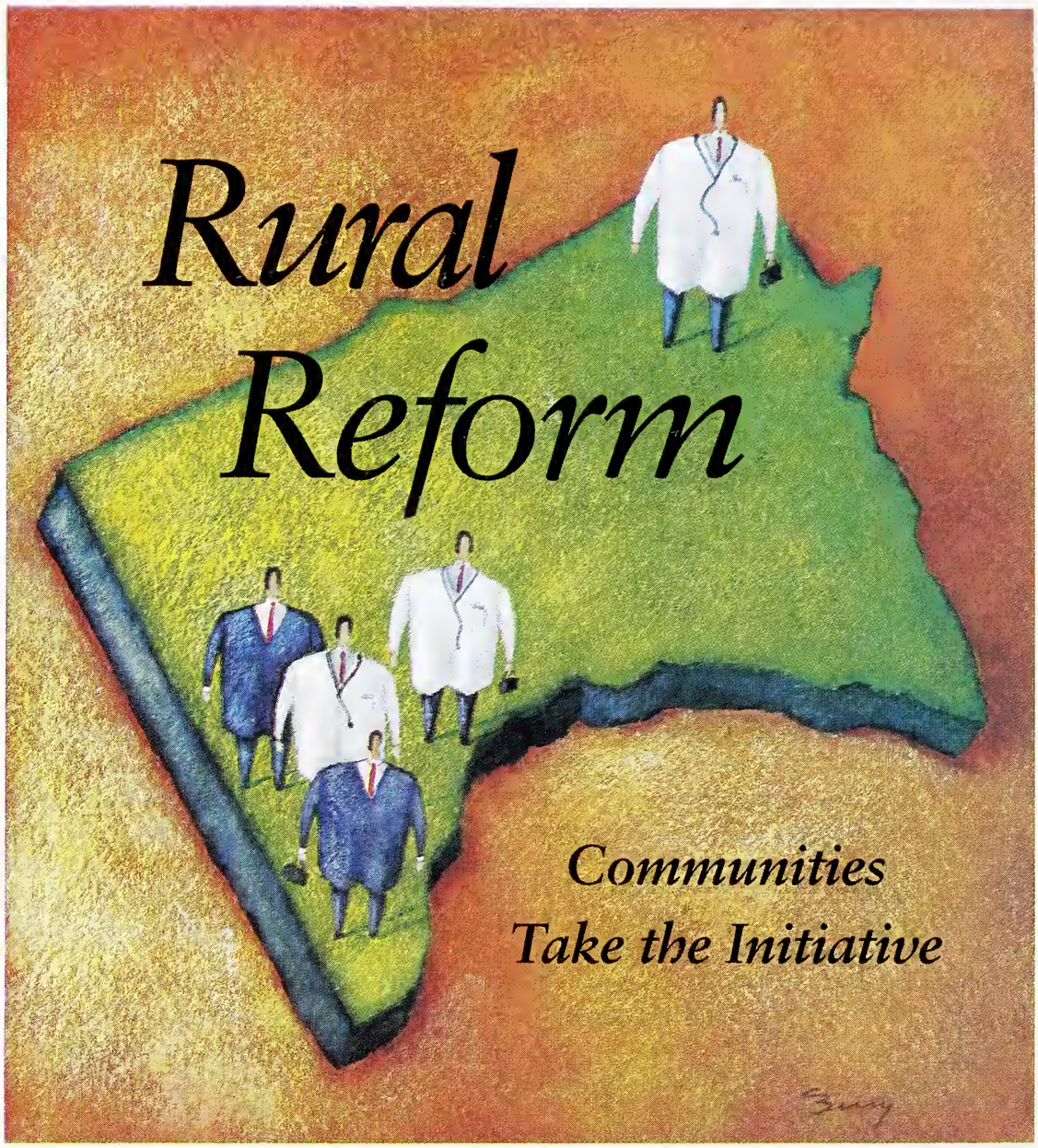


ILLUSTRATION BY JOHN BERRY

This is the story of how two Minnesota towns, undaunted by the gargantuan task of reforming health care, started simply, informally, and locally to cut health care costs and improve quality. The result is two dramatically different approaches to rebuilding the foundation of rural health care delivery.

. . . . . .

Miriam K. Feldman

Plans for what is now called Pioneer Health Systems, Inc., grew out of a casual breakfast meeting, where the conversation was peppered with a lot of "what ifs." When it is up and running, this Willmar-based plan may be among the first community integrated service networks (CISNs) in the state, meeting the Legislature's mandate to provide a continuum of services for a fixed fee to a defined population, in this case the folks in a 14-county region of west-central and southwestern Minnesota. The other initiative, known as the Owatonna Health Care Partnership, began over a couple of Cokes at a local restaurant. It was conceived by five area businesses, the local hospital and clinic, HealthSpan hospitals in the Twin Cities, and the Mayo Clinic. It is now one of several health plans offered to employees at the five partnership businesses in Owatonna's community of 20,000.

On paper, these two health initiatives couldn't look more different. Pioneer was catalyzed by state efforts to reform the health care system and is designed to adhere to all the legislative requirements to become a CISN (for more information on CISNs, see "The MinnesotaCare Act of 1994," page 17). The push for change in Owatonna came from the private sector. It was designed as a cost-cutting measure and as a way to meet community needs. The health care partnership was not driven by health system reform, per se, but, of course, it will reform the way health care is delivered in that community.

Despite their differences, these two initiatives have more in common than not. Both are attempting to create viable health care delivery systems in rural Minnesota, where the delivery infrastructure, like that in the rest of rural America, is crumbling. And they are doing so in their own way, which means starting slowly and adapting their plans to community needs.

There's a lot at stake here. If these plans succeed, they will provide much-needed health care to places where that care no longer can be taken for granted. What's more, they could become models for other Minnesota providers, who by July 1997 are expected to deliver care through integrated service networks (or CISNs), or else adhere to the dictates of a regulated all-payer system.

The goal of these initiatives is to maintain primary care at the local level. "There's no reason for primary care not to be provided in rural areas," says Ira Moscovice, Ph.D., director of the Rural Health Research Center in the Institute for Health Services Research at the University of Minnesota.

To succeed, initiatives such as the ones in Willmar and Owatonna must be perceived as "win-win" situations for everyone involved. For rural areas, "winning" means financial stability and a reduction of physician isolation, says Moscovice, who is a national authority on rural health care. Capitation is one way to achieve those ends, he says, because it guarantees a set of patients for primary physicians. On the other side, secondary and tertiary providers "win" when they are drawn into networks by referrals from local primary care physicians.

Reform is hard work, though, demanding trust, money, and creative energy. In rural areas, it will require the commitment of physicians, who are, by nature, suspicious of anything that smacks of a mandate from the outside—from Washington, or even from St. Paul.

> "The reasons people go out to practice in rural areas are somewhat counter to reform. They're out there because they want to get out of the bureaucracy."
>
> –Ira Moscovice, Ph.D.

"The reasons people go out to practice in rural areas are somewhat counter to reform," Moscovice says. "They're out there because they want to get out of the bureaucracy. That's why they didn't practice medicine in an urban area. They really did want to have personal relationships with the community. So this is an intrusion upon them."

The risk of imposing urban-based plans on rural communities is that physicians will leave, Moscovice says. "If those decisions get made outside of the local community, a person is going to say, 'Why am I out here?' A lot of reasons physicians are out there disappear professionally if they can't control what they do."

Despite the potential risk of alienating physicians who want to maintain the status quo, Moscovice and other proponents of reform measures say the time is ripe for changing the way rural health care is delivered. The challenge will be convincing physicians to accept reform.

That's happening, just slowly, says Terry Hill, executive director for the Minnesota Center for Rural Health in Duluth. "I've noticed that health care providers are coming to realize that they need to network," says Hill, who believes that without networks, the physician shortage in rural Minnesota will only get worse. Currently,

nearly 400 physicians are being actively recruited in areas where only 50 to 60 physicians tend to move each year. When you talk about reform, says Hill, the question isn't "are we going to have to?" The question is "how?"

The answer to that question might be found in Owatonna and Willmar, two communities that have gotten a jump on reform. Although the two initiatives are different, key ingredients in both have been a desire for change, a commitment of time, and a spirit of cooperation.

The Owatonna Partnership

The Owatonna Health Care Partnership brought community employers and providers together on an equal footing for the first time, so they had to learn how to work together, says Rick Kraus, who is manager of corporate human resources at Federated Mutual Insurance Co., one of the five businesses involved in the Owatonna partnership. "Partnerships or coalitions can be very volatile. When you get a group of employers together and try to reach consensus, that can be difficult. But when you get a group sitting down with providers, it becomes even more complex."

The Owatonna Health Care Partnership differs from other coalitions, such as the Business Health Care Action Group in the Twin Cities—a group of 21 employers that combined their purchasing power to induce providers to change medical and administrative practices. "The BHCAG sent out requests for proposals to health care providers saying, 'We have X lives. If you want to serve our health care needs, here's what you have to do,' " says Richard Sleiter, president of the Owatonna Hospital. But the Owatonna group is a true partnership, he says (although it's not formalized as a legal entity). "We sat down across the table and talked about the needs for the business's employees and dependents. ... That's the way it started. The business leaders in our community believe our community is stronger when there's a strong physician group and hospital."

After more than 18 months of contract negotiation, the Owatonna group began delivering care in January. The initiative was driven by cost concerns and largely led by the Owatonna Clinic, says Sleiter. "They believe that when health care is managed, dollars will be saved, quality will be enhanced, and duplication will be avoided."

Cost may have driven the effort, but quality was the focus from the start, Kraus says. "We felt if we could address some quality issues, then the costs would be a byproduct of that." After months of meetings, the group finally agreed to define quality to mean that the health care provided is "necessary and appropriate, that it is effective and delivered efficiently, and that the consumer is satisfied with the care received."

Primary care is the key to the Owatonna plan. Enrollees agree to seek their primary care at the Owatonna Clinic and the Owatonna Hospital and are referred outside to the HealthSpan system in the Twin Cities or to Mayo Clinic for specialty care. Going outside the plan for primary care requires a higher copayment.

The plan, with all its pros and cons, was introduced to employees of the five partnership companies as a managed care program, Kraus explains. On the plus side, employees were told that it offers a reduced premium, full coverage of preventive care, and streamlined utilization review and reimbursement practices. What's more, employees won't pay higher premiums this year, while premiums for the other health care plans offered through the companies may increase by 6 percent to 7 percent.

On the downside, employees will give up some choice by agreeing to stay within the plan's network. About 3,200 employees—more than half—signed up for the new plan. With dependents factored in, about one-fifth

Initiating Rural Reform

Where to Start

Lyle Munneke, M.D., recalls asking Sen. Linda Berglin, DFL-Minneapolis, how to form ISNs in rural Minnesota. Her response: "The legislators have given you the opportunity. Now take it and run with it." But it's not that easy, says Munneke, who has been practicing family medicine in Willmar for 34 years. Communities need more than a mandate for change; they also need help. "It's like if you have three or four children, and it's time for them to learn to ride a bike or roller skate. You're busy, so you say, 'Now go ride it.' Some are going to ride it, some won't have the courage, and some won't ride," he says. "We don't need to be spoon fed, but we need a lot more than that."

Others share Munneke's concern that changing the way health care is delivered is a daunting prospect. "Missing are the resources to put these things together," says Terry Hill, executive director of the Minne-

of the town's population joined the Owatonna Partnership's health plan in the first enrollment period.

It's too early to tell whether the plan will meet its goals, but the new group aims to keep costs for 1994 at or below last year's. Some savings are expected by avoiding duplication of services. The new plan will allow more coordination of services and better communication between specialists and primary care providers, says Kraus. "We've enhanced the role of the primary care physician," he says, explaining that physicians will stay involved in the care, even after they've referred a patient out for specialty care.

Keeping physicians involved will be crucial to the plan's success, says Marvin Dehne, regional health services officer with HealthSpan Health Systems. "The physicians are the ones who are setting up the practice parameters and guidelines, rather than an outside source. It's a positive arrangement. If they're going to be effective in any of the networks, the physician's commitment to discipline is going to be required."

What if Owatonna had done nothing? "We'd be fighting the same dumb battles we were fighting before," says Terry Tone, administrator of the Owatonna Clinic. "Prior authorization, usual and customary battles over price, blaming the insurance companies, and the insurance companies blaming us. And seeing poorer care.

"We're saying, 'We're convinced this is the best care.' I really believe that, and so do the doctors."

Pioneer Health Systems

Change in Willmar, which is headquarters to Affiliated Medical Centers (AMC), a 95-physician multispecialty group, is coming about more slowly and for different reasons than change in Owatonna. Reform efforts in Willmar evolved out of an interest in meeting the state's mandate to create CISNs.

AMC (which has branch clinics in Marshall, Redwood Falls, Litchfield, New London, Benson,

sota Center for Rural Health. Establishing an ISN requires technical and legal expertise, as well as money to hire experts who can help redesign the system. "If we're serious about health care reform in rural areas, then we'd better be serious about allocating some dollars to make it come about," Hill says.

Assistance is available through the Office of Rural Health, which was established under MinnesotaCare legislation. Last year, the Legislature appropriated $100,000 for technical assistance in creating ISNs, money the Office of Rural Health will use to establish a toll-free information line and to publish a how-to resource manual. Both are still in the works. Chari Konerza, director of the Office of Rural Health, has conducted four informational workshops around the state. In addition, this spring, the Legislature appropriated $200,000 for direct loans to rural communities that want to create CISNs.

While part of Konerza's job is to help communities understand how to create networks, she doesn't presume that every community will do so. "Even if they don't form an ISN, it's good for them to go through the networking, because it brings them closer together and more able to work together," she says. "We have communities out there who are 14 miles apart and don't talk."

Konerza says that each community, regardless of its particular dynamics, will have to address similar questions when talking about forming an ISN. She suggests the following questions to get started:

- Who will be involved?
- What is the mission statement?
- How large is the service area?
- Will administration be contracted out?
- How will claims be processed?
- How do we select a lawyer and/or a facilitator?
- How do we acquire actuarial services?

"I think it's a big job, and that's why [communities] need someone to help them through the process," Konerza says. "There are many different ways it can happen. At this point they're only limited by their own sense of creativity." (See also "Principles of Community-based Rural Reform, page 23.)

—*MKF*

Hancock, and Atwater) was concerned that if it was not actively involved in defining how health care would be delivered for the region, someone outside the community would dictate change. But AMC knew it couldn't manage on its own—it needed a partner with managed care experience. So AMC approached Blue Cross and Blue Shield of Minnesota (BCBSM), with whom it had a longstanding relationship, to see if the two organizations could develop something that would be compatible with the state's mandate to create CISNs. Pioneer Health Systems was born. Under the new arrangement, AMC will continue as an independent, autonomous organization providing medical care, while BCBSM will contribute its expertise in such areas as claims processing and data reporting.

"Health care providers are coming to realize that they need to network."

—Terry Hill

Pioneer will apply to become a CISN when the state opens the process July 1, according to its executive director Edward Black, who says Pioneer will have a twofold mission. It will offer a new health care plan to the region's 212,000 people, and it will consult with providers to help strengthen the area's delivery system.

The Pioneer CISN is in the formative stages, with AMC and BCBSM still figuring out what kind of plan to offer and how to build a provider network. The group is conducting market research to assess local attitudes about managed care and holding meetings with employers to learn what kind of plan they want. "We think that a primary care model delivery system can be most effective, but we need to find out what employers think," Black says. "We don't want to build a boat that nobody wants to sail on. We don't want to design a system that nobody wants to buy into."

The venture is structured so that the for-profit Pioneer will sell services to the not-for-profit CISN, New Pioneer. Pioneer, which bears the financial risk, is run by a six-member board of directors—three from AMC and three from BCBSM—with each holding an equal number of the company's 2,000 shares.

"We've got a partnership in which each recognizes what the other brings," says Richard Wagenman, vice president of health services for BCBSM. "So there is mutual respect for what both bring to the table. It's a recognition of the importance of working together to accomplish something and to be honest and to lay the issues on the table that need to be addressed."

Not everyone is so sanguine about the joint venture. Lyle Munneke, M.D., has practiced family medicine in Willmar for the past 34 years. Although he's not opposed to change, he questions the way Pioneer introduced its plan to the community. Munneke, who's not a member of the Pioneer venture, says he and many other physicians didn't learn about the proposed network until they picked up the newspaper. He uses words like "concerned," "fenced in," and "dominated," to explain how he feels about Pioneer.

Munneke's overriding concern is that the new plan represents one more example of how medicine is losing its personal touch. Medicine, he says, is going the way of the small business, which has been swallowed up by corporate enterprises that sell the same products in shopping malls from coast to coast. "I'm afraid you're going to have a lot of that in Minnesota," he says. "You're not going to have the locally owned shoe stores or a home-town restaurant. That's what I'm seeing happening to health care. Is that what we really want?"

Over time, as Pioneer involved local providers in discussions, Munneke has tempered his feelings about the organization. While he is still unsure of the impact Pioneer will have on the region, he believes the organization is not against him or the other local doctors, although he still worries about having to submit to the group more than he wants. His real beef is with politicians. "I get tired of the politicians playing games with the providers out here," he says. "Most of us in rural Minnesota don't like somebody from the outside telling us what we have to do." He doesn't deny the need for change. "It's how the change is going to come about and what we have to say about it," that worries Munneke, one of four physicians with Family Practice Medical Center.

Darrell Carter, M.D., a family practice physician in Granite Falls, about 40 miles from Willmar, says there's a lot of paranoia among non-AMC physicians, who worry about how they will fit into the network. Ultimately, they fear that the CISN could make the already difficult task of recruiting physicians to the area impossible. "The network could make it more unattractive to recruit," Carter says, explaining how there's no way his clinic of four family practice physicians and one physician assistant can compete with AMC. Carter works 70 to 80 hours a week, about twice that of an AMC physician. And he's on call several times a week, as opposed to once every two weeks for the doctors in the large organization. Salaries may be equal, he says, but on an hourly basis, there's no comparison. "It's near impos-

sible to recruit to communities of our size (population 3,500). New grads would rather work a 40-hour week."

Carter dismisses the argument that networks will make recruitment more attractive by offering needed support to physicians. "It's a naive concept. That's not the world out here," he says. "If you have four physicians, somebody's going to be on call. The network of Willmar, 40 miles away, isn't going to help us."

Carter, who is a member of Pioneer's 22-member advisory board, probably will be invited to join the new network. "We want every qualified physician to be part of our CISN," Black says. "It's generally a physician shortage area, so we need the cooperation of the physicians."

That prospect doesn't appease Carter, who says that even if he were to join the network, it would be as a plan provider, so he wouldn't get AMC benefits. With the plan still on the drawing board, Carter won't say whether he will join the network. "I don't know what it's going to look like," he says. "It's a nonentity."

Like Munneke, Carter's gripe is with the Legislature, more than with Pioneer, which is, after all, only trying to follow a legislative mandate for change. The Legislature, he says, has no understanding of rural needs.

Confronting Rural Reform Throughout Minnesota

The Willmar and Owatonna experiences may become models for other rural reform efforts, but they can't be duplicated. Ultimately, every community in the state will have to confront reform in its own way. "I think a community-based approach is much better than people in Washington telling the nation what to do, or even people in the state Capitol telling all of Minnesota what to do," says Owatonna's Kraus. "Much of what's going on here in Minnesota might work better in the large metro areas, but I don't think it addresses some of the issues in rural Minnesota." MM

Miriam Feldman is a free-lance writer in Minneapolis.

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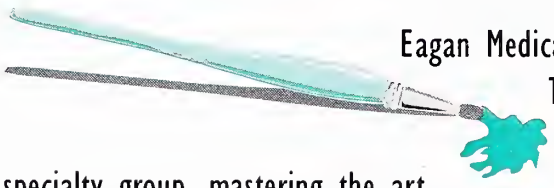

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The MinnesotaCare Act of 1994

The 1994 Legislature passed new laws defining health system reform in Minnesota, continuing its efforts to achieve universal health care coverage.

David Renner, Molly Sigel, and Theodore Thompson, J.D.

The 1994 legislative session may best be described by a quote from an anonymous House of Representatives member who said, "Never have we all worked so hard or spent more time to accomplish so little."

The "short" session started off with a flurry of activity. It appeared as though MinnesotaCare and other significant legislation would move through the Legislature quickly and that the session would be over by mid-April. However, the fate of most key issues was not decided until the early morning hours of adjournment day, Saturday, May 7. The fate of MinnesotaCare wasn't finally determined until May 10, when Gov. Arne Carlson held a press conference to reluctantly announce his intent to sign the MinnesotaCare Act of 1994 into law.

Interest and excitement over MinnesotaCare was absent from the very beginning of the legislative session. This was due, in part, to the lack of surprises in the legislation introduced by Sen. Linda Berglin, DFL-Minneapolis, and Rep. Lee Greenfield, DFL-Minneapolis. The legislation reflected the recommendations of the Minnesota Health Care Commission and the commissioner of health. The legislation delayed implementation of a universal standard benefits set, integrated service networks, and the regulated all-payer option, thus putting off the controversy over these elements until next session.

Nonetheless, MinnesotaCare's passage this year as Chapter 625 continues the state's commitment to redesign the health delivery system under a managed competition model and achieve health care coverage for all Minnesotans. The creation of accountable delivery systems through the development of integrated service networks (ISNs) is still a cornerstone of the Legislature's vision.

The Basics

In an effort to increase competition with the existing large health plans, the MinnesotaCare Act of 1994 creates a new entity called a community integrated service network, defined as a health plan with fewer than 50,000 enrollees. CISNs are allowed an earlier implementation date than ISNs to provide CISNs an advantage as they compete to offer an alternative product.

This year's act moves Minnesota closer to the ultimate goal of universal coverage. By July 1, 1997, every resident is required to have some form of minimum coverage. In addition, starting on this date, the amount of underwriting and rating that health plans and insurers can do will be severely limited. All health products must be community rated and be fully portable. In addition, insurers cannot deny care based on health status and cannot use pre-existing condition exclusions.

The time line to achieve full implementation of the delivery system reforms is delayed a year, until July 1, 1997. This year's legislation also delays implementation of the regulated all-payer option (RAPO), which was established in last year's legislation to encourage providers to participate in ISNs. The new act also clarifies that RAPO is intended to be a legitimate delivery option for providers, purchasers, and consumers who prefer to participate in a fee-for-service system.

The following article is not intended to be a summary of every issue in, or an extensive legal analysis of, the entire MinnesotaCare Act. Rather, it highlights some of the major provisions found in Chapter 625.

Community Integrated Service Networks

Chapter 625 defines a CISN as "a formal arrangement licensed by the commissioner ... for providing prepaid health services to enrolled populations of 50,000 or fewer enrollees." At least 51 percent of the CISN governing board members must be residents of the CISN service area, and at least 40 percent of the board members must be consumers elected by the enrollees.

The commissioner of health will begin accepting license applications for CISNs on July 1, 1994. A licensed CISN can begin marketing its services to consumers and purchasers upon licensure; however, it cannot begin providing coverage to enrollees until January 1, 1995. The licensure standards for CISNs are based on the

HMO requirements with modifications to the net worth requirements, the reporting requirements, and the benefits set.

The minimum net worth requirements for a CISN are reduced slightly from the existing requirements for an HMO. Minimum net worth requirements are equal to the greater of:

- $1 million;
- 2 percent of the first $150 million of annual premium revenue plus 1 percent of premiums over $150 million;
- 8 percent of annual health services costs, except those paid on a capitated or managed hospital payment basis, plus 4 percent of annual capitation and managed hospital payment costs; or,
- four months of uncovered health care costs.

The net worth requirements are phased in over three years—50 percent of the funds are required at time of start-up, 75 percent by the end of the first year, 87.5 percent by the end of the second year, and 100 percent by the end of the third year.

A CISN can also reduce the net worth requirement by using accredited capitated providers (ACPs). A CISN that has contracts with ACPs who are willing to accept risk can reduce the net worth requirements by the "percentage of risk ceded," as long as the minimum net worth never becomes less than $1 million. To be accredited as an ACP, a provider entity must submit sufficient information to the commissioner of health to establish that the entity has the operational capacity to provide the covered services. The provider entity must also agree to provide services to enrollees for 120 days without payment if the CISN becomes insolvent.

In the event that a CISN becomes insolvent, the commissioner of health must determine whether any existing health plans are willing and able to provide replacement coverage for the enrollees. If there are no willing health plans, the commissioner will randomly assign enrollees to other health plans serving the area. The assignment of enrollees will be in proportion to the market shares of the other health plans serving that area. The commissioner also has the authority to assess a surcharge on all existing health plans to pay for the unpaid expenses and claims of an insolvent CISN.

The benefits set for a CISN is the same as the benefits set required for HMOs, except that a CISN can impose deductibles of up to $1,000 per person per year, as long as total out-of-pocket expenses do not exceed $3,000 per person or $5,000 per family per year. The deductible cannot be assessed on preventive services.

Forums to Discuss 'The Next Step'

The Minnesota Medical Association is planning forums throughout the state to discuss the 1994 MinnesotaCare legislation and provide physicians and clinic managers the tools necessary to plan future delivery systems. The forums, called "MinnesotaCare: The Next Step!" will help participants understand integrated service networks, community integrated service networks, health care cooperatives, and the regulated all-payer option. All forums will include a light buffet at 5:30 p.m. and will run from 6 p.m. to 8:30 p.m. The forums cost $30 for MMA members and $50 for non-members. To register, or for more information, call Vicki Westling at the MMA, 612/378-1875 or 800/999-1875.

The forum dates and locations are as follows:

- St. Paul, Thursday, July 14
- Mankato, Tuesday, July 19
- Rochester, Wednesday, July 20
- Duluth, Monday, July 25
- St. Cloud, Tuesday, July 26
- Moorhead, Wednesday, July 27

Integrated Service Networks

The implementation of integrated service networks (ISNs) is delayed two years. The 1993 Legislature directed the commissioner of health to begin licensing ISNs as of July 1, 1994. Chapter 625 delays this at least two years, allowing that the voluntary formation of ISNs "will begin after rules have been adopted, but not before July 1, 1996." This delay is intended to provide time for CISNs to become legitimate competitors.

By July 1, 1997, all health care must be delivered through ISNs, CISNs, or through the regulated all-payer option (RAPO).

Because the ISN implementation is delayed, decisions on such difficult issues as solvency standards and benefits set requirements were also delayed. The commissioner of health is directed to develop a universal standard benefits set and report back to the Legislature by January 1, 1995. The benefits set will be developed with the help of an advisory committee. The solvency standards for ISNs will be developed by the commissioners of health and commerce and will be effective no later than January 1, 1996.

Regulated All-Payer Option

Although questions remain about the effectiveness of the regulated all-payer option (RAPO), Chapter 625 clarifies that RAPO is intended to be a legitimate option for providers. The act states that the purpose of RAPO is "to provide an alternative to integrated service networks for those consumers, providers, third-party payers, and group purchasers who prefer to participate in a fee-for-service system."

This act also delays the implementation of RAPO. Beginning July 1, 1994, the commissioner of health must start phasing in the standardized billing requirements to be used by all payers. The phase-in of the RAPO reimbursement system begins January 1, 1996, or after the rules are adopted, whichever is later. The reimbursement system must be fully implemented by July 1, 1997.

The commissioner of health will adopt a RAPO fee schedule based on the Medicare Resource-Based Rela-

tive Value Scale. It will utilize a Minnesota-specific conversion factor to ensure that it is set at a level "consistent with current relevant health care spending."

To assist in developing the fee schedule, the commissioner of health must convene an advisory committee. The members must include "a broad array of health care professionals that will be affected by the fee schedule." The advisory committee must submit recommendations to the commissioner of health by November 15, 1994, with the commissioner's final report due January 1, 1995.

The commissioner must develop a "statewide volume performance standard" for use as an expenditure target for providers to ensure that spending within RAPO is consistent with achieving the established statewide growth limits.

Universal Coverage

Chapter 625 continues efforts to achieve universal health care coverage by July 1, 1997. Article 6, section 1, states, "It is the commitment of the state to achieve universal health coverage for all Minnesotans by July 1, 1997." To achieve this goal, the following objectives have been established:

1. Every Minnesotan shall have health coverage and shall contribute to the costs of coverage based on ability to pay;
2. No Minnesotan shall be denied coverage or forced to pay more because of health status;
3. Quality health care services must be accessible to all Minnesotans;
4. All health care purchasers must be placed on an equal footing in the health care marketplace; and
5. A comprehensive and affordable health plan must be available to all Minnesotans.

Effective July 1, 1997, every Minnesota resident will be required to obtain and maintain a qualifying amount of health coverage. This is contingent upon the state providing the necessary funding to subsidize premiums for all low-income persons who meet the eligibility standards.

Also effective July 1, 1997, health coverage must be sold on a guaranteed issue basis, include no underwriting restrictions, contain no pre-existing condition exclusions, be fully portable, and be community rated. All of these reforms to the insurance market are intended to be implemented only after the Minnesota Health Care Commission completes a survey of the uninsured, evaluates the effect of existing reforms on the uninsured population, studies the various factors that affect health care affordability, and recommends a plan for implementing a stable, long-term funding system for all government health programs. All of these studies are due back to the Legislature before next session.

The long-term health care funding study must include recommendations for a broad-based tax. The two taxes specifically mentioned are income and payroll.

Self-Insured Capitated Products

Under a major new policy adopted in Chapter 625, large, self-insured employers will be able to offer capitated products to their employees without being licensed as HMOs. This will provide more flexibility for ERISA-exempt employers to begin using capitation.

This provision applies to employers with at least 1,500 employees. The minimum number of employees drops to 750 as of January 1, 1995. An ERISA-exempt employer wishing to offer a capitated product must agree to meet to the following conditions:

1. pay the 2 percent provider tax;
2. pay the 1 percent premium tax effective July 1, 1996;
3. pay the Minnesota Comprehensive Health Association assessments effective July 1, 1995;
4. comply with the 2 percent pass-through;
5. comply with the data and administrative simplification requirements in MinnesotaCare; and
6. provide coverage to any employee or dependent, regardless of health status.

In addition, any ERISA-exempt employer providing a capitated product must agree not to bear risk in excess of the program's expected costs, nor carry stop-loss coverage with an attachment point lower than 120 percent of the program's expected costs.

The ability of self-insured employers to provide capitated products sunsets December 31, 1997.

Exclusive Contract Prohibition

All provider contracts entered into on or after May 11, 1994, are precluded from restricting a person's right to provide health services through another provider group or health plan company. This provision ensures that the intent of last year's law allowing providers to participate in multiple ISNs is followed. No health plan or provider entity can ask a provider to enter into an exclusive arrangement unless that provider is an employee.

The prohibition also precludes a person from voluntarily entering into an exclusive contract with a health plan company. This prohibition was adopted to protect provider groups that are unable to negotiate with larger entities because of lack of market share. It does not apply to existing contracts or those that are voluntarily renewed after this date. The prohibition sunsets January 1, 1997.

Expanded Network of Allied Independent Providers

Effective January 1, 1995, all non-staff model health plan companies with more than 50,000 enrollees are required to establish an expanded network of "allied independent providers." To participate in the expanded network, a provider must:

1. meet the plan's credentialing standards;
2. agree to the terms of the provider contract; and
3. agree to comply with all the plan's managed care protocols.

The managed care protocols may require that the enrollee first obtain a referral from the health plan; the protocols may limit the number and length of visits

similar to the limits on like providers within the preferred network; and they may require ongoing management and review of the care given by the allied provider.

The health plan is allowed to charge higher premiums and copayments for enrollees choosing the extended network as long as they are "actuarially justified and approved by the commissioner." The health plan is required to pay the expanded network providers the same rate per unit of service it pays to the allied independent providers who are in the preferred network.

The act defines "allied independent providers" as any of the following providers who also have direct billing authority: audiologists, chiropractors, dietitians, home health care providers, marriage and family therapists, nurse practitioners, advanced practice nurses, occupational therapists, optometrists, opticians, outpatient chemical dependency counselors, pharmacists, physical therapists, podiatrists, licensed psychologists, psychological practitioners, licensed social workers, and speech therapists.

Action Plans for All Health Plans

In an attempt to increase accountability for existing health plans, Chapter 625 requires each health plan licensed by the state to file an action plan with the appropriate commissioner beginning July 1, 1994. These action plans are intended solely for the purpose of providing better information to consumers, purchasers, and the community. The action plan must include the following:

1. a detailed description of methods, procedures, standards, qualifications, criteria, and credentialing requirements for providers;
2. the number of full-time equivalent physicians by specialty, nonphysicians, and allied providers used to provide services;
3. the number and type of providers necessary to deliver cost-effective health care to the plan's enrollees;
4. the action taken or planned to use information from report cards, outcomes studies, and complaints to improve quality;
5. the policies and procedures for enrolling and serving high-risk and special needs populations; and
6. the action taken or intended to be taken to offer coverage to rural communities.

A health plan company with 50,000 enrollees or fewer can meet the action plan requirements outlined above by stating that it has no policies, procedures, practices, or requirements, or has not undertaken any of the activities. The statements must not be misleading, and they must be truthful.

Administrative Simplification and Electronic Data Exchange

In an attempt to reduce the health care costs related to paperwork, Chapter 625 adopted what is referred to as the Minnesota Health Care Administrative Simplification Act of 1994. Last year's MinnesotaCare Act established the Administrative Uniformity Committee, which met over the last year to develop uniform billing and claim forms. That committee's recommendations served as the basis for this law.

Beginning January 1, 1996, all institutional providers who are not using an electronic data format must use the HCFA 1450 form. All noninstitutional providers, except dentists and pharmacists, who are not using an electronic data format must use the HCFA 1500 form. (Similar standard forms are required for dentists and pharmacists.)

Also beginning January 1, 1996, all health care provider organizations, health care providers, group purchasers, and patients must be given unique identification numbers. For provider organizations, the number will be the federal tax identification number; for providers, it will be HCFA's unique provider identification number (UPIN); for purchasers, the federal tax identification number; and for patients, their social security number "encrypted" to ensure privacy.

This article of the act also promotes the increased use of electronic data exchange to process claims, and it creates the Minnesota Center for Health Care Electronic Data Interchange. The center is intended to:

1. coordinate electronic data interchange education and training in the state;
2. develop a health care data interchange education curriculum;
3. administer a resource center to serve as a data interchange; and
4. provide technical assistance in the development of implementation guides, as well as in legislative, legal, and confidentiality requirements.

Universal Standard Benefits Set

Chapter 625 directs the commissioner of health to work in consultation with the Minnesota Health Care Commission and the commissioners of human services and commerce to develop a universal standard benefits set. To assist in the development, the commissioner of health must appoint an advisory committee with members representing health care providers, purchasers, consumers, health plans, and counties. The recommendations developed must be reported to the Legislature by January 1, 1995.

In addition to determining the services to be covered by the universal standard benefits set, the commissioner of health must present recommendations to the Legislature for no more than five different cost-sharing options for health plans to offer. These options may vary from a low-premium option with high copayments, to a high-premium option with very low copayments. The Legislature must approve the universal benefits set.

As of January 1, 1996, all health plans must offer the universal benefits set as an option to enrollees. As of January 1, 1997, all health plans must offer the universal standard benefits set within one of the five cost-sharing options allowed.

Health plans can choose to offer separate supplemental coverage for services not included in the universal standard benefits set.

Health Care Cooperatives

The purpose of the Health Care Cooperative Act is to provide another option for entities wishing to form integrated health care systems. The "purposes" section of this article states that "the goals of containing health care costs, improving the quality of health care, and increasing the access of Minnesota citizens to health care services ... may be further enhanced through the promotion of health care cooperatives."

The law requires health care cooperatives, which are based on rural agricultural cooperatives, to be licensed as HMOs or indemnity insurers. The policyholders, who are members of the cooperative, elect the governing board.

The act also establishes "health provider cooperatives," which are member organizations consisting of providers, provider clinics, or hospitals that are willing to accept capitated payments. The law states that establishing a health provider cooperative does not violate the corporate practice of medicine prohibition and is not considered restraint of trade.

Miscellaneous

MinnesotaCare enrollment delay. Chapter 625 delays enrollment in the MinnesotaCare Program for low-income people without children. Under the original HealthRight Act, single individuals and married couples without children were to be eligible for MinnesotaCare coverage July 1, 1994. However, this year's act moves the eligibility date to October 1, 1994, and reduces the eligibility level from 275 percent of the federal poverty level to 125 percent.

Increased size of the Minnesota Health Care Commission. The Legislature increased the size of the Minnesota Health Care Commission by two consumer members, bringing its membership to 27. One of these members is to be appointed by a consortium of citizens with disabilities to represent consumers with physical disabilities or chronic illness. The other member is to be appointed by the Mental Health Association of Minnesota, in consultation with the Minnesota Chapter of the Society of Americans for Recovery, to represent consumers with mental illness or chemical dependency.

Pilot study on health plan quality. The commissioner of health, in consultation with the Data Institute, must develop a pilot study to collect comparative data from providers on "opportunities and barriers to the provision of quality, cost-effective health care." The study will look at administrative barriers, time spent obtaining prior approval, continuing education opportunities provided, economic incentives and disincentives, and inclusion of physicians and other providers in administrative decision making.

Voluntary purchasing pools. Chapter 625 provides authority for employers, groups, and individuals to voluntarily form purchasing pools solely for the purpose of negotiating and purchasing health coverage. Participants in a purchasing pool must live in a common geographic region, be employed in similar occupations, or share some common factor approved by the commissioner of health.

Moratorium on health plan mergers. In an attempt to address what some people see as too much market concentration in too few health plans, this year's MinnesotaCare Act imposes a moratorium on mergers or acquisitions by certain health plans. This moratorium affects health plans that serve more than 5 percent of the insureds in the state or more than 10 percent of the insureds in the seven-county metropolitan area. The moratorium expires July 1, 1996.

Pass-through enforcement. To better ascertain how third-party payers are complying with the requirement to pay the pass-through of the 2 percent provider tax, the act requires all payers that are regulated by the state to include in their annual license renewal documentation indicating their compliance with the pass-through. If the commissioner of health or commerce believes that a third-party payer is not complying, he or she can fine or censure the payer.

Medical education and research. Chapter 625 continues the Medical Education and Research Task Force another year to study the impact of health reform on education and research. The task force may include up to 20 members representing affected groups, including the Minnesota Medical Association. The task force is to report to the Legislature by February 15, 1995.

24-hour coverage plan. The act requires the commissioners of health, labor, and industry to submit a plan to the Legislature by January 1, 1996, that incorporates and coordinates the worker's compensation health component into ISN coverage. Referred to as "24-hour coverage," this could eventually eliminate health coverage from the worker's compensation program altogether and include it in general health coverage.

Anesthesia services study. This chapter requires a study related to anesthesia services to compare different third-party reimbursement practices and different employment arrangements between anesthesiologists and certified nurse anesthetists. It also must include findings regarding the most appropriate methods to provide these services to ensure cost-effective, quality care. The commissioner of health's report is due to the Legislature by January 15, 1995.

Vetoed provisions. Gov. Arne Carlson executed his authority to "line-item veto" two provisions in the MinnesotaCare Act of 1994. His authority to do so only applies to items appropriating money. He vetoed a provision that had appropriated $200,000 to the attorney general to "work cooperatively with the commissioner of health in an effort to increase Minnesota's Medicare reimbursement rate." Carlson said he vetoed this provision to reduce state spending and because he was concerned that it is unwise to take legal action against the federal government when the state is requesting waivers from it.

Carlson also vetoed a transfer of the 2 percent tax going to the general fund. The Legislature had attempted to reduce the amount of money transferred from the Health Care Access Account to the general fund. Last

year's law had transferred more than $38 million to the general fund to help pay for additional costs in the Medical Assistance program. Because those additional costs did not materialize, the Legislature tried in Chapter 625 to reduce this transfer by $21.7 million. The governor vetoed the provision, thereby reducing the amount of the 2 percent tax going to fund the MinnesotaCare program and instead appropriating it to fund other state programs.

Conclusion

The 1995 legislative session is shaping up to be one filled with very difficult decisions regarding the MinnesotaCare program and reform in Minnesota. The future of the regulated all-payer option, MinnesotaCare funding, and approval of the universal benefits set will be important to the MMA. Providers received commitments from leaders in both the House and Senate, key legislators involved with MinnesotaCare, and even from the governor, that the 2 percent provider tax was only intended as a "temporary" funding source and that a broad-based tax would be implemented. With the 1994 elections behind them, legislators may just implement it next year. MM

David Renner is director of legislation and public policy at the Minnesota Medical Association. Molly Sigel is associate director of state legislation. Theodore Thompson is legislative counsel for the MMA.

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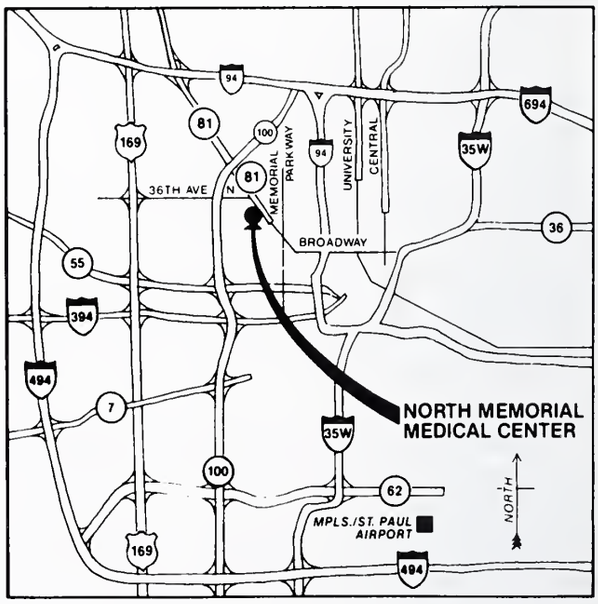

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Principles of Community-based Rural Reform

This month's health reform article examines problems related to rural health care delivery and describes a community-based model for implementing reform.

Kristen Gloege

Rural health system reform is of great concern at local, state, and national levels. For a variety of reasons outlined in this article, it is also a complex and complicated issue. Because each community's health delivery system is inextricably woven into its historical, social, political, and economic tapestry, government, business, and the nonprofit sector must work closely together to set and achieve common goals.[1-3] Studies suggest that efficient and effective health care delivery systems based on community needs can be developed in rural Minnesota using a broad-based, regional strategic planning process.[1-5]

This article describes the demographics of rural Minnesota important to providing health care, suggests guiding principles for bringing communities together to create a viable rural health care system in Minnesota, and provides a local example of comprehensive community-based planning.

Characteristics of Rural Minnesota Communities

The varied composition of the state's regions creates distinctive opportunities for, as well as unique barriers to, the effective delivery of health care services. It has been argued that what works in one area of Minnesota may not work in another. Further, although rural regions in Minnesota share many features, they are not carbon copies of one another. To understand the challenges of rural health system reform in this state, it is important to have some knowledge of Greater Minnesota's demographic make-up.

According to the 1990 Census, rural Minnesota accounts for nearly 30 percent of the state's population—or about 1.3 million people of a total 4.4 million population.[6] However, the population is dropping in several rural counties. Between 1980 and 1990, 40 rural counties (of 87 total counties in the state) experienced population loss. The majority of Minnesota's counties have population densities ranging from 50 to 100 people per square mile, but five frontier counties (Kittson, Lake of the Woods, Koochiching, Lake, and Cook) in northern Minnesota have fewer than six people per square mile.[6] Such low density areas have difficulty supporting even a single physician practice.

Although Minnesota has a strong tradition of group practice and managed care (85 percent of Minnesota family physicians practice in group settings or multispecialty clinics compared with 44.4 percent nationally), health maintenance organizations have not successfully penetrated rural Minnesota.[12] In 1992, only about 7.5 percent of the population in outstate Minnesota was enrolled in HMOs. This compares with about 43.5 percent in the seven-county metro area for the same year.

"Older" and "poorer" are words commonly ascribed to rural populations. Rural counties in Minnesota have a disproportionate share of the population over age 65. While about 12.5 percent of Minnesota's entire population was 65 or older in 1990, more than 20 percent of the population in rural counties was over the age of 65.[6] Furthermore, statewide income data indicate that the incidence of poverty is greater in many rural areas of the state.[6] In five rural counties, more than 20 percent of the population is below the poverty level, compared with 10.2 percent of all Minnesotans. In an additional 26 counties, between 14 percent and 19 percent of the population is below the poverty level.[6]

These demographics complicate health system reform. The 1994 MinnesotaCare legislation, for example, does not incorporate public programs (such as Medicare, Medical Assistance, General Assistance Medical Care, the MinnesotaCare program, and workers' compensation) into the domain of integrated service networks (ISNs) or community integrated service networks (CISNs), thus putting many rural health care services outside the realm of system reform.

Inadequate insurance, or none at all, is an all-too-common backdrop to the delivery of health care services to rural Minnesotans. A Minnesota study of differences in health insurance between urban and rural dwellers

found rural residents were more likely than Twin Cities residents to be uninsured for all of the previous year or to have purchased individual insurance policies, which typically have higher premiums and cover fewer services.[7] The study also indicated that rural employees with health insurance policies pay a higher share of premiums and have policies that cover fewer services than their urban counterparts.

A University of Minnesota study of Minnesota farm families showed similar results. In that study, 9.4 percent of respondents had no health insurance, and of those with coverage, many had insurance with high coinsurance and deductible provisions and limited coverage of services other than hospital and physician care. Consequently, out-of-pocket health care costs for farm families are very high. Eighteen percent of the farm families surveyed spent 25 percent or more of their income on health insurance and services, and nearly 10 percent spent 40 percent of their net income on health care expenses.[8]

A widespread shortage of physicians in rural Minnesota is another critical problem that threatens communities' abilities to sustain effective and efficient delivery systems. The primary care physician-to-population ratio in Minnesota's 71 non-metropolitan counties is 55.2 physicians to 100,000 residents.[6] According to the Office of Technology Assessment report, "Health Care Access in Rural America," Minnesota ranks 24th among the 50 states in non-metropolitan primary care physician-to-population ratios.[9] Minnesota's current Health Professional Shortage Area (HPSA) designations reflect the need for more primary care physicians to serve many rural areas of the state. Thirty-five of the 39 federally designated primary care medical HPSAs are rural, including eight entire counties and portions of 38 others.[6] In 1993, a statewide survey indicated that 394 physicians, including 303 primary care physicians, were in demand in rural Minnesota (defined as those areas outside the Twin Cities, Rochester, and Duluth).[10]

These demographics have left Minnesota hospitals struggling to maintain market share and to assure the survival of clinical programs. Eighteen rural hospitals have closed since 1985, and the financial vulnerability of many others has raised concern about access to emergency care and other hospital services for hundreds of rural Minnesotans.[11] A struggling hospital often erodes public confidence and leads many residents to seek care elsewhere, thus, hastening the hospital's demise.

Exacerbating the problem, compared with other states, Minnesota has a large number of very small hospitals. Three-fourths of the 158 licensed hospitals in the state have fewer than 100 beds, including 91 hospitals with fewer than 50 beds.[11]

Other well-documented difficulties in maintaining viable rural health care delivery systems include limited availability of technological services because of high cost and personnel shortages, aggressive competition by urban providers, a shortage of obstetricians and certain other providers because of malpractice costs, and the inherent limitation on services imposed by small populations.

Market research has consistently shown that rural residents often go outside the community for hospital, physician, dental, mental health, and other services.[1] The University of Washington has accumulated perhaps the largest database on the perceptions and utilization patterns of rural residents. The data show that certain services consistently fail to meet local expectations.[1]

Bruce Amundson, M.D., of the Washington-Alaska-Montana-Idaho (WAMI) Area Health Education Center, believes that communities must take responsibility for the problems themselves.[1] He says four critical factors have contributed to ineffectual local problem solving, with migration from rural areas a consequence. These factors, common to many rural communities, are: 1) quality of care problems, such as poor clinical outcomes, unacceptable provider interpersonal skills, excessive office waiting times, insensitive office staff, inadequate technology, and confusion over billing practices; 2) lack of CEO-, physician-, or trustee-led initiatives that would attempt to understand problems; 3) ineffectual performance by many providers, managers, and trustees; and 4) the effect of poor teamwork and chronic conflict among local providers.[1] Amundson suggests that the primary reason for the demise of human services in most rural communities is the failure of communities to meet the needs and expectations of local residents and to effectively address local problems in the delivery system. He says his findings support the argument that communities should direct greater effort toward building market share and addressing why so many people leave their communities.

Principles and Strategies for Promoting Community-based Reform

There is a resurgence of interest by rural communities in establishing cooperative community structures to organize and manage care.[1-4] Although rural Minnesota's experience with managed care has been limited and at times turbulent, providers and communities will need to cooperate in comprehensive community-based strategic planning to overcome physical and political barriers to reform and to create new ways to develop and enhance delivery systems that keep patients and patient dollars in their communities.[13,14]

It is widely acknowledged that the strongest potential for redesigning and strengthening rural health care delivery systems resides within the communities themselves.[1-3,5] Health care and community leaders must resolve to cooperate with one another in planning for their shared future, to accept outside technical assistance, and to initiate and evaluate change.[3]

Amundson has proposed the following conceptual framework incorporating 10 principles to approach community reform systematically.[1]

1. **Shift responsibility to the larger community.** Create a community-wide organizational group to take the lead in the development process. Community-based

planning will require commitment, involvement, and participation by these groups: 1) municipal, and in some cases, regional and state government; 2) a broad-based coalition/network of community agencies and organizations; and 3) citizens. All appropriate constituencies should be represented. The community-wide organizational group should be composed of about one-half community and one-half health care representatives, and should include every health and human service entity in the community. A neutral but respected leader with group process skills should be recruited as chair. Ideally, members will be committed, objective, experienced leaders who are willing and able to commit to the tasks.

2. **Use a fully integrated community development model for the process.** Several experiential-based models are now available, most based on community development principles. Choose a model that includes a planning process to determine the critical issues needing attention and to identify who will be responsible for implementing changes and a time line.

3. **Determine the appropriate scope of health services for each community.** No longer can rural health care facilities be everything to everybody. Each community or region should develop an outline of services that clearly defines the continuum of care that residents can expect. Rural communities must examine what services they can appropriately provide.

4. **Perform a comprehensive analysis of current health services.** All major strengths and weaknesses in the health care system must be clearly delineated, including those involving quality of services, leadership, performance, teamwork, customer satisfaction, and utilization patterns. This is a quality- and data-driven process. A community analysis should include individual interviews with community and health care representatives and should be conducted by people from outside the community to ensure that the assessment is as objective and honest as possible. Discussing results of the appraisal during the process will enhance accountability.

5. **Provide education and skills development.** After identifying community needs, the people responsible for meeting these needs should be provided with appropriate training and skills development.

6. **Apply organizational development principles.** Organizational development (group process) skills are essential to ensure that community-based work proceeds smoothly and efficiently. Community residents who have experience conducting meetings, communicating, team-building, and managing conflict should be identified and included in key roles.

7. **Involve a co-facilitator.** Because most communities must address such sensitive issues as hospital board effectiveness, physician interpersonal qualities, and local management skills, participation of an outside, neutral co-leader, accepted by the community-organizational group, is crucial. As reform strategies are identified, this co-facilitator will be in a position to help the community objectively implement its strategies.

8. **Commit financial resources.** Community-based development should be viewed as a necessary investment in the community's economic health. It is essential that communities commit some of their own resources. Local funding is the most readily available source and enhances community ownership of the process.

9. **Complete the cycle.** The cooperative reform cycle includes planning, implementation, evaluation of the outcomes, and refinement of the process.

10. **Address personnel needs.** It will be crucial to develop a coherent, thoughtful, and aggressive recruitment committee and strategy to relieve what is the most pressing problem for many rural communities—personnel shortages.

A Minnesota Example of Community-based Planning

A project known as the Northern Minnesota Rural Health Transition Project, underway in northern Minnesota, utilizes these principles to help hospitals in rural communities make the transition from acute care hospitals to community health centers. The Northern Lakes Health Care Consortium, a broad-based coalition of providers in northeastern Minnesota, obtained funding from the Blandin Foundation in Grand Rapids, Minnesota, to provide $25,000 to $50,000 grants to hospitals and communities to help hospitals become community health centers.[2,3]

The project emphasizes community commitment to the local health care system; team-building focused on hiring consultants with the necessary expertise; comprehensive information gathering, including internal organizational audits and external environmental assessments; hospital board and provider education; community education through an advisory committee that includes such community sectors as commerce, education, government, religion, and health care; management by a part-time community coordinator; strategic plan development, including mission review, assessment of strategic alternatives, and the development of recommended actions; and plan implementation, including resource allocation and ongoing project evaluation.[2,3]

Conclusion

Communities and providers will undoubtedly face obstacles to reorganizing local health care services.[4] Among the challenges will be unifying the efforts of organizations and providers accustomed to high levels of independence; narrowing the scope of services to those needed by the community or region; establishing firm linkages between the physician groups, hospitals, and payers; and developing support systems that integrate and coordinate efforts across the entire system. Moving from a free-standing culture to a system culture is a major shift for all stakeholders, and a change that requires time, patience, and superior management skills. MM

Kristen Gloege, formerly a health policy analyst at the Minnesota Medical Association, recently joined the

Office of Rural Health, Minnesota Department of Health, as a health program representative.

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Recruitment of Family Physicians in Rural Practice

Edwin A. Anderson, Dale Bergeron, and Byron J. Crouse, M.D.

ABSTRACT

We report the results of a study to find out how rural family physicians choose their practice location—information that could allow physicians and practices to be more appropriately and easily matched. We interviewed rural family physicians who completed a Minnesota residency in 1990 or 1991 to determine what factors influenced their final practice selection.

The survey revealed that partners in practice are physicians' greatest concern, followed by geographic location, recreational activities, call schedule, and opportunities for spouse and children. Despite numerous available practice options, it was difficult for physicians to find practices and communities that met the majority of their personal, professional, and familial needs.

This study suggests a need for a physician placement network that would increase retention and help ease the current health care provider shortage in rural Minnesota.

Difficulty recruiting and retaining rural physicians has led to a growing shortage of health care providers in rural Minnesota and is one of our state's most serious health care problems. Over the last 30 years, expansion of medical school classes and creation of new medical schools and programs to train allied health care providers (such as nurse practitioners and physician assistants) increased the overall supply of the nation's health care providers.[1]

Although the number of physicians choosing to practice in larger rural communities has increased slightly, the majority of smaller communities are still grossly underserved.[2] The Council on Graduate Medical Education determined in 1988 that there was a surplus in the total number of physicians across the country, but emphasized that serious primary care physician shortages still existed, especially in rural areas across the United States.[3] This is clearly the case in Minnesota, as indicated by a 1993 Minnesota Department of Health Demand Assessment, which showed that 67% of physician recruitment statewide is for primary care doctors.[4]

The primary barrier to health care access in small communities across the country is the inadequate physician supply. Rural Minnesota needs more than 300 additional primary care physicians, and that number will soon increase, since 20% of all rural physicians in the state are over 65 years old. In addition, the state is experiencing a 50% drop in the number of primary care residency graduates entering rural practice.[4,5]

Currently, the average length of stay for new health care providers in rural areas across the nation is less than two years.[6] Because a strong, positive relationship exists between job dissatisfaction and job turnover, recruitment organizations need to identify the factors most important to physician job satisfaction and help match individuals with practice opportunities that meet their personal and professional needs.[7] Finding a physician to "match" both the practice and the community will help reduce physician turnover and ultimately increase placement in rural communities. The goal of our study was to better understand the process by which family practice residents choose a rural practice.

Methods

We contacted program directors of each Minnesota family practice residency program by phone and asked them to submit a list of residents who completed training in 1990 or 1991. During July and August 1992, we attempted to telephone the graduates who selected non-metropolitan practice locations. Programs represented in the survey are the Duluth Family Practice Residency Program, Duluth, Minnesota; Mayo Clinic Family Practice Residency Program, Rochester, Minnesota; the University of Minnesota Family Practice Residency Program, Minneapolis, Minnesota; and the Hennepin County Family Practice Program, Minneapolis, Minnesota.

Of the 77 residents whose names were submitted, 31 (40%) chose a non-metropolitan practice location. Twenty-four of the 31 physicians who chose non-metropolitan practices were interviewed. Of the seven physicians not contacted, four could not be located and three did not respond to repeated phone calls. All physicians were interviewed by phone and were asked a series of questions to determine:

• how much time and thought went into choosing a practice;

• what factors influenced their particular practice choices;

• what resources they used in their search and how they found the practice opportunity;

• what their primary concerns were in choosing a community in which to live;

• what advice they would offer residents currently looking for a practice site;

• what services and resources would have made the process easier; and

• whether they felt they made the right decision.

Physicians were also asked to rate the degree of influence that a variety of practice and community factors had on their final decision. A scale of one to 10 (no influence to extremely influential) was used to establish the importance of 13 different practice and community-related factors. A series of open-ended questions focusing on these same issues allowed each physician to add other comments and concerns. Results were compiled by tabular analysis.

Results

Residents typically began looking for practice opportunities late in postgraduate year (PGY)-2 or early in PGY-3. Thirteen of the 24 physicians began considering practice sites in their second year of residency training, with most searches beginning in the months of March, April, or early May. Nine of the 10 physicians who started their searches in PGY-3 began considering specific practice sites by late October, and one waited until mid-December. One physician found a practice site in his home town prior to PGY-1 and did not consider other locations. The number of on-site visits per resident ranged from one to 30 with a mean of 6.5, a mode of 5, and a majority visiting five to 10 sites. All of the physicians signed contracts during PGY-3, with 16 signing by January 1.

Most of the physicians first heard of practice opportunities by word of mouth. Several physicians found opportunities through practice fairs and journal advertisements. Physicians who learned of their practice opportunities by word of mouth and through in-house hospital and clinic recruiters were generally satisfied with their situation. None of the physicians contacted were placed by an outside recruiter; residents tended to consider outside recruitment a desperate effort by a practice to secure a physician. A majority felt that these opportunities represented an undesirable situation, and they tended to shy away from practices using this method. Those surveyed felt they had more negotiating power without a recruiter and that recruiters may not present a practice in its true light.

Ten physicians had attorneys review contracts, and nine others asked preceptors or residency program directors for a review. All nine of the physicians who had preceptors or program directors review their contracts found it worthwhile, as did seven of the 10 who had an attorney review the contract. The three physicians who felt the attorney review was not worthwhile commented that their attorneys were not experts in this field, and, therefore, the review was not as valuable as it might have been. Of the five whose contracts were not reviewed, four entered into practices with preceptors, physicians who trained in the same program ahead of them, or family members. One physician signed a non-negotiable contract with the Indian Health Service and did not have it reviewed.

Eleven of the 24 physicians (46%) said a process is needed that would make practice evaluation easier, but nonetheless, 21 of the 24 physicians felt they made the right decision and are happy with their current place of practice. Fourteen physicians plan to remain in their present location until retirement, six plan to remain five to 10 years or more, and one will stay at least two years and has no plans to relocate. Three physicians are dissatisfied with their present situation and plan to relocate in the next two years.

The table shows the degree to which 13 different factors reportedly influenced final choice of practice location. The mean results show that respondents rated partners in practice the highest priority. Geographic location was rated second, with recreational activities and call schedule close behind. Those categories with a mode of 10 were partners in practice, opportunities for children, and opportunities for spouse. Geographic location received a mode of 9, and recreational activity had a mode of 8. Salary, community size, case load, access to technology/large referral centers, and a community's economic situation were rated at the bottom of this list of priorities. (Although all these factors received fairly high ratings, some were more consistently given high ratings as reflected by the lower standard deviation and smaller range of scores.)

Discussion

Physicians in this sample said their most important consideration was the quality of the partners with whom they would work. All of the physicians sought partners who exhibit clinical competence, follow similar treatment philosophies, and have personalities that make them easy to work with. Getting to know the physicians and the practice was a high priority for each of the physicians interviewed. This is especially important in a small group practice, where differences in personality and patient management can easily become significant problems. Physicians should look for partners they can easily get along with. The chance of success is increased when physicians choose partners who share the same medical values and have similar goals in life.[8]

The physicians considered call schedule a key issue and indicated they would not accept being on call more frequently than one day in four. Of the three physicians who plan to relocate in the next two years or earlier, two stated the primary reason for leaving was excessive in-house call. Other studies have shown that physician work load and call schedule are particularly important in retention.[9]

A practice's financial stability is also important. Each practice should allow physicians to review and informally audit the books with the office manager. It is important to look at

the patient base, financial history, assets, and reserves of any group considered.[10] The clinic's economic situation must be sound if the physician plans to become a member in the practice, and this is one area respondents believe should be given higher priority. Practices recruiting a physician should make information available on their patient base, earning potential, and long-term stability to aid the potential partner in evaluating the practice.

Most residents will begin looking for practices in late PGY-2 or early PGY-3; therefore, hospitals and clinics need to focus their recruitment efforts at this time. Recruitment strategies must be as unique as the institutions doing the recruiting.[11] When considering a rural practice career, physicians need to consider professional isolation, access to continuing medical education, available back-up coverage, and the continuity and quality of care they will be able to offer their patients. Practices that are actively recruiting physicians must show that small-town practice can offer a wide variety of cases, challenges, close physician-patient relationships, as well as benefits not found in a typical urban practice setting.[12] By focusing on the positive aspects of rural practice and meeting the needs of physicians entering practice in small towns, communities can place themselves in a much better position to attract physicians and ease the rural physician shortage.

Surprisingly, salary by itself did not play a significant role in most physicians' final choice. Most said the salary differential between practices was not great. The consensus was that residents should not be lured into a commitment by salary or signing bonuses. Although residents may have incurred a substantial amount of debt, educational loans are not that difficult to repay. Practices should offer a competitive salary, but studies have shown that attempts to use large salaries to override negative features will not improve retention.[9]

Despite the number of practices looking for physicians, it may be difficult to determine who is hiring in a geographic area of interest. Physicians do not have easy and immediate access to information about all practices in need of additional physicians. Therefore, many good practice opportunities may be unknown or overlooked.

To help resolve this issue, organizations such as private, nonprofit centers, as well as state offices of rural health, have evolved to assist rural physicians, hospitals, and communities. One example is the Minnesota Center for Rural Health, a private, nonprofit organization working in partnership with the Office of Rural Health at the Minnesota Department of Health. Together, they have developed the Minnesota Practice Opportunity Directory and the Minnesota Physician and Mid-Level Practitioner Demand Assessment, and they offer practice and contract evaluation services.[4,13]

Professional organizations have also developed services, such as the American Academy of Family Physicians Placement Service (formerly known as the COMPASS program), which matches physician needs and family interests with community and practice resources. These programs

Table

*Degree to which factors influence choice of practice location (N=24)**

Influencing factor	*Mean*	*Std. dev.*	*Mode*	*Range*
Partners in practice	9.021	0.972	10	7-10
Geographic location	8.250	1.629	9	5-10
Recreational activity	8.188	1.241	8	6-10
Call schedule	7.646	1.716	†	5-10
Opportunities for children	7.467	2.108	10	3-10
Opportunities for spouse	7.400	2.609	10	1-10
Vacation time	7.271	1.588	7	4-10
Clinic's economic situation	7.087	1.934	6,8	3-10
Salary	6.562	1.771	5	3-10
Size of community	5.938	2.257	7	2-10
Case load	5.917	2.190	7	2-9.5
Access to technology and large referral centers	5.896	1.888	7	2-9
Economic situation of of the community	5.354	2.305	†	1-10

*The table reports the data obtained when physicians were asked to quantify the degree to which factors influenced their final choice of practice location (on a scale of 1 to 10, with 1 signifying no importance and 10 extremely high importance).

†No clear mode.

offer services designed to provide placement and retention assistance to communities and physicians, and they allow physicians to quickly and efficiently examine practice opportunities. Physician and community profiles provide an outline to help identify needs and assist in making a good match.

Our current study should be interpreted as indicative of trends and priorities of a specific set (1990 or 1991) of Minnesota family practice residency graduates entering rural practice. While some of the same issues may be common to other areas of the country, additional studies need to be done to confirm this. Concerns with such factors as quality of partners, geographic preferences, and recreational needs, however, are universal.

Conclusions

Among the physicians we surveyed, professional concerns about the quality of partners, call schedule, and practice stability, along with such personal considerations as geographic location, access to recreational activities, and the ability of a community to meet family needs were of highest priority in selecting a practice site. The results of this study indicate a need for a network of services that allows physicians to find the most suitable practice. To assure successful physician placement, those recruiting must take the time to know the personal and professional needs of physician candidates and their families, and the candidate must carefully evaluate both the practice and the community. Improving the physician/practice/community match greatly increases the chances of long-term success for all parties. MM

Acknowledgment

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Edwin Anderson is a medical student at the University of Minnesota School of Medicine in Duluth, Minnesota. Dale Bergeron is program director for recruitment and retention at the Minnesota Center for Rural Health in Duluth. Byron Crouse is associate professor and head of the Department of Family Medicine at the University of Minnesota School of Medicine in Duluth.

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The Monitor
News For Minnesota Physicians

Announcements

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Meet at the St. Cloud Civic Center for the 1994 MMA Annual Meeting

Wednesday, September 28
Thursday, September 29
Friday, September 30

• • •

MinnesotaCare Seminars Are Scheduled

The MMA will offer the seminar "MinnesotaCare: The Next Step" in locations throughout the state to give physicians and clinic managers the information they need to plan their future delivery systems. The forum schedule is listed below:

Thursday, July 14, St. Paul

Tuesday, July 19, Mankato

Wednesday, July 20, Rochester

Monday, July 25, Duluth

Tuesday, July 26, St. Cloud

Wednesday, July 27, Fargo/Moorhead

Forums will begin with a light buffet at 5:30 p.m. and will end at 8:30 p.m. The registration fee is $30 for MMA members and $50 for non-members. To register, call Vicki Westling at the MMA, 612/378-1875 or 800/999-1875.

AMA Adopts Minnesota Resolutions

Ending Family Violence Is a High Priority

The Minnesota delegation helped keep the issue of family violence in the forefront at the American Medical Association Annual Meeting June 12 to 16 in Chicago. The Minnesota Medical Association, together with the Medical and Chirurgical Faculty of Maryland and the American Society of Addiction Medicine introduced a resolution calling on the AMA to continue its campaign against family violence. The amended resolution, which was adopted by the AMA House of Delegates, commits the AMA to the following efforts:

• The AMA, working with the AMA Alliance, will continue its leadership role in bringing physicians and other professionals and their organizations into collaborative efforts to prevent and reduce family violence in our society.

• The AMA will continue to make family violence a centerpiece public health issue and devote the necessary resources to support a continuing campaign to reduce family violence.

• The AMA Board of Trustees will review for future implementation the recommendations from the work groups at the March 1994 American Medical Association/American Bar Association National Conference on Domestic Violence and will report back to the House of Delegates at the 1994 Interim Meeting.

Report Targets Violence in Medical Workplace

Last year, the 1993 AMA House of Delegates adopted a Minnesota resolution calling on the AMA Board of Trustees to review studies of abuse in the medical workplace with particular attention to physician practices, medical education settings, and hospitals and to develop model guidelines for physicians to use in their efforts to eliminate abuse. This year, the board's completed study was adopted by the AMA House of Delegates. The report, which taps the Hennepin County Medical Society (HCMS) to play a key role, calls for the following activities:

• The AMA will discuss with Hennepin County Medical Society that organization's ongoing efforts to address violence and abuse in medical settings and work with it to disseminate its program, evaluation, and findings.

• The AMA will work with Hennepin County Medical Society and other interested medical groups to develop guidelines on the reduction of abusive behavior in physician practices and other medical settings.

• The AMA, through its Department on Mental Health, will continue to monitor the scientific literature in this field and provide reports to the House of Delegates on this issue whenever appropriate as part of the annual update report on the Family Violence Campaign.

• The AMA will urge the Liaison Committee on Medical Education

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through its Part II Annual Questionnaire to collect data on the incidence of abuse in medical school.

AMA Adopts Auto-authentication Resolution

On the floor of the AMA House of Delegates, Thomas A. Stolee, M.D., successfully argued in favor of a Minnesota resolution asking the AMA to study the issues raised by computerized auto-authentication in lieu of the physician's signature to validate medical records and asking the AMA to work with the Health Care Financing Administration (HCFA) and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to find a solution that will allow its continued use.

"Auto-authentication saves time and money for physicians and hospitals," Stolee said. Physicians don't have to go to the medical record to sign it. Their dictated medical record entries are transcribed, added to the current medical record of the patient, and forwarded to the physician. If the physician takes no corrective action, authentication is automatic. Although there is no evidence that this procedure causes problems that affect patient care, HCFA recently reversed its policy allowing auto-authentication and began to require a physician's signature, phone call, or electronic signal to validate a medical record. Continued use of auto-authentication of medical records may jeopardize a hospital's participation in Medicare and may threaten hospital JCAHO accreditation.

Despite almost unanimous testimony in favor of the Minnesota resolution, the AMA Reference Committee considering it recommended a substitute resolution that reversed the intent of the original resolution and expressed caution about the use of auto-authentication. The AMA House of Delegates rejected the reference committee's recommendation and adopted the original Minnesota resolution.

Lonnie R. Bristow, M.D., former chair of the AMA Board of Trustees, presented C. Randall Nelms, M.D., president of the MMA, an award for increasing membership in the AMA in 1993. The award was presented at the 1994 National Leadership Conference. Bristow is now AMA president-elect.

The American Medical Association Hospital Medical Staff Section (HMSS) Assembly also adopted the Minnesota auto-authentication resolution.

AMA-HMSS Adopts Immunization Policy Report

Responding to a 1993 Minnesota resolution, the American Medical Association Hospital Medical Staff Section (HMSS) Assembly adopted a report that gathers in one place the myriad policies and recommendations on disease testing and immunization for physicians and other health care workers.

Faced with outbreaks of tuberculosis and mounting pressure to protect the public against infectious diseases, many hospitals are implementing aggressive employee immunization programs and infection control polices. These policies raise some questions. It is not clear, for instance, whether members of the medical staff who are not hospital employees must comply.

At the 1993 Interim Meeting, an MMA-HMSS resolution asked the AMA-HMSS Governing Council to "study the legal and regulatory aspects of requiring physician members of HMSS to be immunized in order to prevent infection of patients and employees, and to prepare guidelines concerning immunization of members." At the June 1994 meeting, the AMA-HMSS adopted, in lieu of the MMA-HMSS resolution, Report D of the Governing Council. This comprehensive document summarizes the AMA testing policy, JCAHO standards, the Americans with Disabilities Act (ADA) requirements, the Centers for Disease Control recommendations, and Occupational Safety and Health Administration (OSHA) rules. The report also includes the following conclusions reached by the Governing Council:

- AMA policies and CDC recommendations provide a scientific basis for hospital/medical staff policies on testing, immunization, and infection control. The AMA continues to oppose mandatory testing for HIV and HBV. Physicians who perform exposure-prone procedures should voluntarily be tested at a frequency appropriate for the risk. All health care workers should observe universal precautions and proper infection control guidelines.
- To gain widespread acceptance of hospital policies, the medical staff should be involved in policy development.
- Until the Department of Justice responds to the AMA's May 6, 1993, request for an advisory opinion on whether the ADA applies to the non-

employee members of the medical staff, the Governing Council believes that ADA requirements on medical examinations and infectious disease should be followed. People infected by HIV, HBV, or TB are considered disabled under the ADA, and an employer may limit their job opportunities if there is significant risk to health or safety that cannot be eliminated by reasonable accommodation.

• A physician impairment committee should determine on a case-by-case basis whether an infected physician can adequately and safely provide medical care.

• There should be a mechanism to address the physical and mental health needs of medical staff members.

Minnesota Physicians Are Prominent at AMA Meeting

MMA physicians play a major role in the AMA. At the AMA Annual Meeting, Stolee served on AMA Reference Committee B dealing with legislative issues. Gail L. Gamble, M.D., chair of the MMA Board of Trustees, served on Reference Committee C dealing with medical education issues. Gamble is also the new chair of the AMA Women in Medicine Advisory Committee. Audrey M. Nelson, M.D., an AMA delegate, was reappointed to the AMA Advisory Committee on Group Practice Physicians.

William E. Jacott, M.D., who is serving his second three-year term on the AMA Board of Trustees, recently concluded a term as vice-chair of the AMA Board. William R. Kennedy, M.D., serves on the AMA Council on Scientific Affairs.

The Minnesota AMA delegates are: Robert D. Christensen, M.D., E. Duane Engstrom, M.D., A. Stuart Hanson, M.D., Audrey M. Nelson, M.D., Ben P. Owens, M.D., Thomas A. Stolee, M.D., and Richard B. Tompkins, M.D. The alternates are: Theodore L. Fritsche, M.D., Frank J. Indihar, M.D., Carolyn J. McKay, M.D., Lyle Munneke, M.D., C. Randall Nelms, M.D., Bruce A. Norback, M.D., and Thomas L. Peyla, M.D. • • • • •

Patient Protection Act Makes Progress

Sen. Paul Wellstone, D-Minn., successfully offered two provisions of the AMA's Patient Protection Act as amendments to Sen. Edward M. Kennedy's, D-Mass., health system reform bill, the first version of the president's legislation to pass a full congressional committee. The Kennedy bill passed the Labor and Human Resources Committee June 9 on a vote of 11-6, guaranteeing that the full Senate will confront health system reform this summer. The AMA/Wellstone proposals are as follows:

• Health plans must make public their criteria for hiring and firing physicians and other providers.

• Plans must give providers at least 60 days' notice of a decision to dismiss them or not to renew their contract and must tell them the reasons for this decision.

The Senate labor committee adopted the amendments by a vote of 13-4, with one nay vote coming from Sen. David Durenberger, R-Minn.

Another Wellstone amendment establishing standards for utilization review by health plans passed the committee by voice vote. The AMA strongly supports this amendment.

The AMA first introduced the Patient Protection Act at a news conference May 23, saying the legislation would guarantee that patients and their physicians—not insurance companies—will make decisions about medical care. The Patient Protection Act was introduced in the House as H.R. 4527 by Reps. Collin Peterson, D-Minn., and Wayne Allard, R-Colo., and in the Senate by Wellstone and Sen. Conrad Burns, R-Mont., as S. 2196.

This legislation stops short of calling for an "any willing provider" system. It allows health plans to set credentialing standards that limit their number and types of providers, but not in an arbitrary or secretive fashion.

In addition to the provisions introduced by Wellstone, the Patient Protection Act includes the following proposals:

• Economic profiling of physicians must be adjusted to recognize case mix, severity of illness, age of patients and other practice features that might account for unusual costs.

• Plans must allow physicians a voice in policy-making, including decisions on the new technology and procedures to be covered.

• If a claim is denied as "not medically necessary," the claimant or provider must be able to appeal to an independent medical consultant or peer review group.

• Plans must tell physicians who is doing utilization review.

• Health plans must tell prospective enrollees what the plan pays for; what they will have to pay for themselves; what hoops they must jump through before a physician can treat them; and provide survey results revealing how other patients feel about the health plan.

• Plans must give patients the choice of three plan options: a health maintenance organization or preferred provider organization, a traditional insurance plan, or a benefit payment schedule plan. A benefit plan covers the services in the benefit package, which may be provided by any physician on a fee-for-service basis.

• Patients who choose managed care must also be able to choose a point-of-service option that allows them to pay extra to see an out-of-plan physician.

William E. Jacott, M.D., AMA trustee; C. Randall Nelms, M.D., MMA president; and Mark Vukelich, MMA director of communications, met with Twin Cities reporters and news editors to promote this legislation. • • • • •

Announcements

Nominations are Now Being Accepted

The MMA Nominating Committee is beginning the process of nominating candidates for the MMA offices of president-elect, vice-president, secretary, treasurer, speaker of the MMA House of Delegates, and vice speaker of the House of Delegates. If you are interested in running for election as an MMA officer, or if you would like to nominate another MMA member, contact your representative on the Nominating Committee. Elections will be held at the 1994 MMA Annual Meeting in St. Cloud in September.

The members of the nominating committee are: A. Stuart Hanson, M.D., chair, Donald S. Asp, M.D. (East Metro), Nicholas P. Bernier, M.D. (North Central), Audrey M. Nelson, M.D. (Southeast), Theodore S. Olson, M.D. (Northwest), Ben P. Owens, M.D. (Northeast), David M. Pence, M.D. (Southwest), and Joseph M. Tombers, M.D. (West Metro).

In Brief Will Be Back Next Year

The Minnesota Medical Association publishes the *Monitor in Brief* from January through June to keep members up to date during the legislative session. You can expect to receive your next issue in mid-January 1995.

Use Thrombolytics to Treat Heart Attacks, Urges HTAC

The state took its first stab at providing information that could be used to set practice parameters and make treatment decisions. The Minnesota Health Care Commission issued the report of its Health Technology Advisory Committee (HTAC) on the use of tissue plasminogen activator (t-PA) to treat acute myocardial infarction.

The choice of treatment is controversial because the two most common ways to dissolve the sudden obstruction of a coronary artery differ widely in price, but differ only slightly in their effectiveness. The report provides information to aid decision making, but does not endorse a particular thrombolytic treatment.

Thrombolytics Save Lives

The report found that thrombolytic therapy saves lives, but it's not being used often enough. Although thrombolytic therapy effectively dissolves clots and restores blood flow to the heart, the study estimates that only 30 percent of the heart attack patients admitted to Minnesota hospitals receive this therapy.

The report also found that the benefits diminish with time. Patients' chances of survival are best if they are treated with thrombolytics within one hour of the onset of symptoms.

The report points out the implications of its findings:

- Emergency room personnel and physicians should streamline ER procedures to treat patients within 30 minutes of arrival in the hospital ER.
- County, health regions, and public health officials should consider health education aimed at cutting down the time it takes a patient to recognize symptoms and get to the hospital.

Treatments Compared

Both streptokinase and t-PA were found safe and effective. The report noted that t-PA is particularly effective for anterior infarcts or when therapy is begun within four hours after onset of symptoms. It is associated, however, with a slightly increased risk of stroke and costs a whopping $2,000 more. (There are approximately 2.5 additional strokes per 1,000 patients associated with the use of t-PA.) The report recommends that because of its higher cost, t-PA should be used only for patients who, in the opinion of the treating physician, are most likely to benefit.

The report lays the facts on the table. It would cost approximately $200,000 to save a person's life by using t-PA rather than streptokinase. Approximately 35 additional lives would be saved in Minnesota each year at a total cost of approximately $7 million.

This report suggests several uses for this information.

- Integrated service networks may use it to develop standard protocols to assure that t-PA is used when it will be most effective.
- The Practice Parameters Advisory Committee may develop guidelines to help physicians decide which patients are most likely to benefit.
- Regional Coordinating Boards may monitor how medical facilities and networks are addressing these issues.

Ironically, this report, which was meant to provide information on cost-effective treatment, may end up increasing the amount of money spent on treating heart attack victims. More important than the choice of *which* thrombolytic to use is that *some* thrombolytic therapy should be used much more often and much more quickly.

Announcements

When a Reporter Calls

A media interview doesn't have to be a horror story. When a reporter calls, you can ask for time to prepare rather than launching right into a question-and-answer session that could put you on the spot. Ask the reporter what questions you'll be expected to answer and arrange a convenient time for the interview. This will give you an opportunity to gather your thoughts and to look up any facts or figures you might need. If you would like advice and assistance, call Mark Vukelich at the MMA, 612/378-1875 or 800/999-1875, and he will help you prepare for a successful media interview.

Fax on Demand

You may call 800-DIAL-MMA, enter your FAX number, and request that any of the following information be faxed directly to you:

- Summary of the 1994 MinnesotaCare Act
- MMA ISN Position Paper
- MMA RAPO Position Paper
- MMA domestic violence and abuse referral information
- Summary of the 1993 legislation creating ISNs

Minnesota Kids Bring Injury Prevention Message to Congress

At the SAFE KIDS Summit in Washington, D.C., the children joined William Nielsen of Johnson & Johnson, sponsor of the summit; C. Everett Koop, M.D., former U.S. Surgeon General; and Sen. Christopher Dodd, D-Conn.

The MMA helped identify the Minnesota children who attended the National SAFE KIDS Summit May 9 to 11 in Washington, D.C., and told Congress what they've learned from personal experience about the importance of injury prevention. As a result of the summit, the Kennedy health reform bill now includes a SAFE KIDS amendment addressing injury prevention.

Michelle Marthaler of Granite Falls, who was nominated by her physician, Darrell L. Carter, M.D., and Molly Prom of Apple Valley joined 100 other children at a hearing of the Congressional Subcommittee on Children, Family, Drugs and Alcoholism chaired by Sen. Christopher Dodd, D-Conn. Along with C. Everett Koop, M.D., former U.S. Surgeon General and chair of the National Safe Kids Campaign, several children testified on the importance of including injury prevention in health system reform.

Both Minnesota children who attended the summit know the pain, suffering, and economic and emotional hardship caused by injury. Marthaler, 12, was riding in the back of her grandfather's pickup truck, holding onto a mattress, when she fell and suffered a severe head injury. She was airlifted to North Memorial Medical Center where she spent the first two weeks of her seven-week hospital stay in a coma. Now recovered, Marthaler brought a strong message to Congress: "If you're on anything with wheels—whether it's a motorcycle or bike or roller blades, wear a helmet." She and Prom urged Minnesota Sens. Paul Wellstone and David Durenberger to support injury prevention legislation.

Prom has undergone surgery four times for multiple injuries sustained several years ago when a drunk driver traveling at approximately 75 m.p.h. veered off the road and struck her family's parked van.

The SAFE KIDS amendment was introduced by Dodd and unanimously adopted as part of the Senate Labor and Human Resources Committee's health reform bill, which passed out of committee June 9. The amendment would provide funds for research on injury prevention and provide state grants for improving safety and for creating public information programs.

LEGAL NEWS

Court Nixes Mental Health Questions on Bar Exam

The Minnesota Supreme Court, in its role as supervisor, ordered the Minnesota Board of Law Examiners to drop three questions about mental health treatment from the state bar application. The court's decision came in response to a petition from the deans and various professors of the University of Minnesota Law School, the William Mitchell College of Law, and the Hamline University Law School asking that mental health treatment questions be stricken from the application.

The questions asked students whether they had been in counseling or mental health treatment in the last 10 years and whether they had taken medication or been hospitalized for emotional disturbance or nervous or mental disorders. The law schools maintained that these questions kept some students from seeking the help they needed. They also charged that the questions grossly invaded personal privacy and violated the Americans with Disabilities Act (ADA).

Without deciding whether the ADA applies, the court said that the prospect of having to answer the mental health questions could cause law students not to seek necessary counseling. Believing that questions relating to conduct can elicit the information needed to protect the public from unfit practitioners, the court ordered the board to delete the questions and to disregard answers already made to those questions in making character and fitness assessments of applicants for the July 1994 bar examination.

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MMA Supports Parents in End-of-Life Dispute

The MMA wrote the Ramsey County Court a letter supporting the right of the parents in the Butcher case to end medical care for their son, who has been in a persistent vegetative state for 16 years. The state is blocking the family's attempt to stop medical treatment and withdraw artificial nutrition and hydration on the grounds that it would be "neglect" for failure to provide "necessary food" under the Minnesota Vulnerable Adult Abuse Act. The state wants the parents to petition the court to become legal guardians for their son and to ask the court's permission to end nutrition and hydration.

After the MMA Committee on Ethics and Medical-Legal Affairs considered this case, the MMA wrote James F. Finley, the Ramsey County Court referee, a letter elucidating the medical-ethical issues. The MMA made the following key points:

• Unless there is an advance directive that names a proxy, the patient's family should become the surrogate decision-maker.

• Parents as natural guardians of their children are generally in the best position to make treatment-withholding decisions.

• It is the MMA's opinion that a decision made in a patient's best interest to terminate artificially administered fluids and nutrition of a patient who is in a persistent vegetative state and has no chance for recovery would not constitute "neglect" for failure to provide "necessary food" under the Vulnerable Adult Abuse Act.

• Surrogates' decisions about medical care should not be challenged as long as they are based on true concern for the patient's welfare. The court should only review decisions about life-sustaining treatment as a last resort.

The MMA called the Butcher family's decision a "deliberate and caring one made after years of contemplation and anguish about the right decision ... with input from health care and other appropriate professionals."

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Court Strikes Down State PAC Limits

Federal Court Judge Paul Magnuson struck down Minnesota's limit on the amount of money an individual can give a political action committee (PAC), ruling that the law violates the constitutional right to freedom of speech. This law had a greater impact on small PACs that rely on big contributions from a few members than it did on larger PACs supported by many smaller contributions.

The judge let stand a law meant to blunt the power of "independent expenditures," which fund campaign activities conducted without a candidate's knowledge or involvement and, therefore, fall outside the state's campaign spending limits. The law allows the opponent of the candidate who benefits from the independent expenditure to exceed the spending limits by the amount of the expenditure. As soon as groups or individuals make a commitment to make an independent expenditure, they must notify the board of ethical practices and the opponent of the candidate who will benefit. The unsuccessful challenge to this law came from the Minnesota Citizens Concerned for Life (MCCL) and the Minnesota Education Association (MEA). These groups, which use the technique extensively, argued that the law is an infringement of the constitutional right to free speech.

Announcements

Dr. Christensen Appointed to Health Care Commission

Gov. Arne Carlson has appointed Raymond G. Christensen, M.D., of Moose Lake to the rural physician post on the Minnesota Health Care Commission replacing Robert Kelly, M.D., who has resigned. The MMA recommended Christensen for this post. Kelly received a certificate of appreciation from the governor for his work on the commission at its June 15 meeting.

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Child Development Workshop

"Partnering with Families," a day-long professional workshop with T. Berry Brazelton, M.D., will be held September 21 at the Radisson Metrodome Hotel on the University of Minnesota campus. The workshop, sponsored by Gillette Children's Hospital, First Years, and St. David's School for Child Development and Family Services, will address early intervention strategies, touch points in child development, and child neglect and abuse issues. The cost is $95 per person. For more information or to register, call·612/939-0396.

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Appointment to the BMP

Gov. Arne Carlson has appointed Elliot V. Troup, M.D., an ophthalmologist at the Roseville Eye Clinic, to the Minnesota Board of Medical Practice.

Growth Limits Extended Through 1997

When the 1994 MinnesotaCare Act delayed the implementation of integrated service networks and the regulated all-payer option, it also extended the transitional provider growth limits through 1997, rather than ending them in 1995 as originally planned.

The 1994 limit on the rate of growth in health care spending is 9.4 percent above the 1993 baseline. The *projected* 1995 growth limit is 8.3 percent above the 1994 limit. The *actual* 1995 growth limit, which may be slightly different because of changes in the regional consumer price index, will be published in the *State Register* by January 31, 1995.

Keep Saving That Data

Compliance methods remain the same. Providers may limit their revenues per patient or their revenues per encounter. If this information is not available, they may limit their fees. Providers don't have to notify the Minnesota Department of Health of their choice. Except for hospitals, providers don't have to submit data, but they must maintain information in case they're audited. The commissioner of health will audit all clinics with more than 100 physicians and will audit a random sample of other providers.

Providers who limit revenues will be monitored on the basis of a two-year average of their revenues. In a change from last year, providers who limit fees will be monitored on the basis of yearly figures.

Figure the "Weighted Average Fee Change"

Fee limits apply to each fee, identified by CPT code. Compliance with fee limits will be monitored on the basis of the "weighted average change" in each CPT code from year to year. If fees change in the middle of the year, multiply the first fee by the number of months it was in effect, multiply the second fee by the number of months it was in effect, then add these two numbers and divide by 12. This will give you the weighted average fee for that code.

Submit Methodology by September Deadline

Providers who limit revenues may have their revenue figures adjusted for case-mix complexity, payer mix, taxes, and assessments, etc. To gain the necessary approval, providers must submit adjustment methodology for 1994 and 1995 data to the Minnesota Department of Health by September 1, 1994. Providers who wish to revise the methodology submitted last year, or to change their method of compliance, must submit revised plans by September 1, 1994. Providers will be allowed to submit changes in their methodology for adjusting 1996 and 1997 data if they submit revised plans by September 1, 1996. No adjustments are allowed for providers who limit fees.

Providers Must Pay Back Revenues Over the Limit

If a provider exceeds the growth limits, the commissioner of health will notify the provider 30 days before taking action. The provider has 10 days to provide an explanation for exceeding the limit. Providers who wish to appeal must mail a written notice of appeal to the commissioner within 30 days after the notice was mailed.

A provider who exceeds the fee or revenue limits must pay back the excess amount during the following calendar year. The money will go into the Minnesota Health Care Access Fund, which is used to fund the MinnesotaCare program.

If you have questions about growth limits or adjustment methodology, call Janet Silversmith at the MMA, 612/378-1875 or 800/999-1875. • • • • •

ANNOUNCEMENTS

Emergency Treatment Parameters for Workers' Comp Expire

The emergency rules governing the treatment parameters for workers' compensation officially expired on Friday, May 13, 360 days after they took effect. The Department of Labor and Industry is developing permanent rules, but they probably won't take effect until October. Until then, the emergency rules are not legally binding, but insurance companies may still use them as guidelines to determine reasonable and necessary treatment.

Proposed permanent rules are expected to be published in the *State Register* in late June, and a tentative administrative hearing on the rules is scheduled for August 2, 3, and 4. After the proposed permanent rules are published, public comments will be accepted for 30 days.

If you have any questions or comments about the workers' compensation rules, contact Molly Sigel at 612/378-1875 or 800/999-1875.

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BMP Will Administer Diversion Program

The Minnesota Board of Medical Practice (BMP) will administer the Health Professionals Services Program, which will assist health care providers who are unable to practice with reasonable skill and safety because of alcohol or drug use or because of mental or physical problems. The program committtee, representing the participating boards of medical practice, podiatry, chiropractic, nursing, dentistry, and pharmacy, designated the BMP as administrating board of the new program. James Knapp, M.D., represents the BMP on the program committee.

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Vacancies Open on DUR Board

There are two vacancies for physician volunteers to serve on the Drug Utilization Review (DUR) Board of the Department of Human Services. The DUR board, an advisory body for the Medicaid DUR program, is responsible for the following activities:

- approval of criteria and standards for both retrospective and prospective DUR;
- application of the criteria to retrospective DUR;
- ongoing educational interventions with pharmacists and physicians concerning therapy problems identified in the course of retrospective DUR;
- helping the DUR Program identify general education topics and develop programs for providers and patients.

Minnesota's DUR Board was formed in 1992 to comply with the Omnibus Budget Reconciliation Act of 1990, which required each state to have a DUR program in operation by January 1993. The goal was to ensure that Medicaid prescriptions are "appropriate, medically necessary, and not likely to result in adverse medical results."

The DUR Board meets at least four times a year from 6 p.m. to 9 p.m. at the Department of Human Services building in St. Paul. There are 12 members on the board, six of whom are physicians. Physicians who are interested in serving on the DUR Board should call Jean Breuer, DUR Program, Department of Human Services, 612/296-6976.

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Aging Project Asks Physicians to Collaborate

More than 200 primary care physicians in Ramsey County will be asked to allow a few of their outpatients to participate in a clinical study designed to help high-risk elderly patients avoid the need for hospitalization or nursing home care. The MMA endorses the geriatric evaluation and management project, called the Minnesota GEM Program, which is conducted by the University of Minnesota Medical School Department of Family Practice and Community Health and HealthEast. The project will study the effectiveness of providing care that addresses social, psychological, functional, nutritional, and financial problems, as well as medical problems.

If one of your patients is selected, an investigator will call to ask if he or she may participate in this study for six months. You will be contacted about any major decisions concerning your patients, and at the end of six months, you will receive your patients back with a detailed clinical summary. If you have questions or comments about this project, contact its principal investigator, Chad Boult, M.D., M.P.H., at 612/627-4462.

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Prenatal Care Utilization in Minnesota

Patterns of Concern, Areas for Improvement

Donna J. Petersen, M.H.S, Sc.D., Greg R. Alexander, M.P.H., Sc.D.,
Peter D'Ascoli, M.D., M.P.H., and John Oswald, M.P.H.

ABSTRACT

We conducted an analysis of prenatal care utilization among Minnesota resident mothers for the years 1990 to 1991 to determine why this state ranks poorly in prenatal care use while its infant mortality rate is one of the lowest in the nation. We found that 6% of women began care in the first trimester yet did not receive an adequate number of visits. These women were more likely to deliver preterm, low birthweight infants than women who started care later. Fifteen percent of women had records missing important data, and these women also had higher rates of poor pregnancy outcomes. Our findings have implications for maternal outreach and follow-up efforts and suggest potential benefits from private and public health collaborations. In addition, efforts to improve the quality of data reporting should begin immediately.

In September 1992, Northwestern National Life Insurance Company (NWNL) published its "State Health Rankings," intended to provide "a snapshot of each state's general health" based on 17 health indicators.[1] Although Minnesota ranked No. 1 in overall state health and has consistently had one of the lowest infant mortality rates in the nation, we ranked only 17th among states in adequacy of prenatal care.[2]

This information has relevance for the Minnesota Health Care Commission, which was established by the Legislature in 1992 and charged with, among other duties, recommending potential cost-saving practice parameters for statewide adoption.[3] Concerned with excessive costs in the neonatal period, the commission has sought to identify and recommend preventive strategies to reduce low birthweight and prematurity, factors associated with neonatal hospitalizations.[4] Minnesota's relatively low ranking of prenatal care adequacy piqued the commission's interest in improving prenatal care utilization as one such strategy. As a result, commission members expressed interest in examining prenatal care utilization among Minnesota resident mothers in an effort to elucidate the reasons for this ranking and develop strategies to increase prenatal care use.

Minnesota's health system reform efforts offer several additional opportunities to improve pregnancy outcomes. Prenatal care has been selected as one of the first three "conditions" for which practice parameters will be developed and has also been targeted for an initial outcomes study. Beyond the immediate effect on early identification and intervention for high-risk pregnancies, prenatal care may well facilitate the mother's future health-seeking behaviors for her children and for other members of her family. Therefore, universal access and availability of comprehensive prenatal care services have become primary public health strategies for promoting maternal and child health in the United States.

In addition to describing our prenatal care utilization analysis, this article identifies why Minnesota women received such a low ranking in prenatal care utilization and describes the demographic characteristics of women at risk for poor prenatal care utilization.

Methods

We selected vital record files of single live births to Minnesota residents for the years 1990 to 1991 for analysis. Cases with clearly implausible gestational age values, i.e., less than 20 weeks and more than 50, as calculated in completed weeks from the date of the last normal menstrual period to the date of delivery, were excluded, leaving records of 131,845 live births for analysis.

The NWNL report relied on data from the National Center for Health Statistics and calculated adequacy of prenatal care utilization according to modification of the Kessner Index.[5,6] For the present analysis, adequacy of prenatal care was derived using the index developed by Alexander and Cornely.[7] This graduated index, called the GINDEX, is a refined version of the Kessner Index and includes the original Kessner categories of adequate, intermediate, and inadequate prenatal care utilization, as well as the additional categories of intensive utilization, no care, and missing data. The intensive utilization category identifies women who receive far more prenatal care visits than would be expected for a normal

pregnancy, potentially indicating a high-risk pregnancy. Both indexes consider the trimester prenatal care began, the number of prenatal care visits, and the gestational age at delivery. Women who begin care in the first trimester of pregnancy and follow the schedule of visits recommended by the American College of Obstetricians and Gynecologists are classified in the adequate prenatal care utilization category.[8] For preterm deliveries, the number of visits for an adequate classification is adjusted downward. Women who initiate prenatal care later than the first trimester or receive less than the recommended number of visits for the gestational age may be classified in the intermediate or inadequate category. These indexes are solely measures of the quantitative utilization of prenatal care and do not consider the content or quality of the services provided.

The mother's race was coded as white, black, American Indian, and other. Educational status was determined to be low, average, or high.* Low birthweight was defined as less than 2500 grams. Prematurity was defined as gestational age of less than 37 weeks. Multiple logistic regression was used to calculate odds ratios for the independent effects of socio-demographic factors on the various measures of prenatal care initiation and adequacy.

Results

Table 1 depicts population characteristics of resident mothers during 1990 to 1991 in Minnesota. Of the total 131,845 live births, 90.5% were to white women, 61.2% were first births, and 78.3% were to married women. Only 2.7% of the live births were to women under age 18. For those reporting the trimester that prenatal care began, 81 percent started care in the first trimester. Less than 1% of women received no prenatal care.

*For adolescents, this was determined by calculating grade achieved for age. For adults, low educational attainment was considered less than high school; average was considered high school; and high was considered greater than high school.

Table 2 provides data on the adequacy of prenatal care utilization according to which trimester care began. (Note that in 15.6% of the cases, one or more data elements necessary for the calculation of prenatal care adequacy were missing from the vital record.) Nearly 60% of the women started care in the first trimester and received an adequate number of visits for their gestational age. However, 6% of women started care in the first trimester and did not receive the recommended complement of visits. These women were classified as having intermediate or inadequate utilization of prenatal care.

Over this two-year period, 4.19% of the newborn infants weighed less than 2500 grams at birth, 0.74% weighed less than 1500 grams, and 6.89% were preterm (<37 weeks gestation at birth). Table 3 displays the percentage of low birthweight and premature delivery by various levels of prenatal care utilization. Women receiving no prenatal care, representing less than 1% of the total population (N=645), exhibit low birthweight and preterm percentages of 21.43 and 29.70. Of particular interest to this investigation are women who began care in the first or second trimester but did not adequately utilize prenatal care throughout their pregnancies. These women bear a disproportionate share of the low birthweight and premature babies. Excluding those receiving no care, women who start prenatal care in the first or second trimester and then do not seek adequate service have the highest risk of low birthweight infants and preterm delivery.

To identify the socio-demographic characteristics of women who did not seek early and adequate prenatal care, we performed three separate analyses using logistic regression. The detailed results of these analyses and the definitions of selected variables are presented in the appendix (page 45).

The first analysis focused on women who started prenatal care in the first trimester. We sought to identify the socio-demographic factors that differentiated women who received the recommended number of prenatal care visits after initiating care from those who received less than that. Of the women who initiated prenatal care in their first trimester, mothers who were unmarried, adolescent (<18 years of age), nonwhite, or who had a low educational

Table 1

Demographic characteristics (1990-91 single live births to Minnesota resident mothers; N=131,845)

Demographic characteristic	Number	Percent
Marital status		
Married	103,256	78.3
Unmarried	28,589	21.7
Race of mother		
White	119,308	90.5
Nonwhite	12,537	9.5
Educational status*		
Low	11,331	9.0
Average	48,367	38.3
High	66,607	52.7
(Missing)†	(5,540)	(4.2)
Age of mother		
Less than 18	3,550	2.7
18-29	81,795	62.1
30 and older	46,474	35.3
(Missing)†	(26)	(0.02)
Parity		
Primiparous	80,031	61.2
Multiparous	50,818	38.8
(Missing)†	(996)	(0.76)
Trimester prenatal care began		
First	97,502	81.0
Second	18,419	15.3
Third	3,810	3.2
No care	645	0.5
(Missing)†	(11,469)	(8.7)

*Educational attainment defined for adults (18+ years of age) as low (<12 years), average (12 years), high (>12 years); for adolescents (<18 years of age) defined as low (2+years below expected grade level), average (within 1 year of expected grade level), high (2+ years above expected grade level).

†Percentages for missing categories based on the total number of cases (N=131,845). Other percentages are based on those cases with non-missing values.

Table 2

Adequacy of prenatal care utilization by trimester prenatal care began (1990-91 single live births to Minnesota resident mothers)

Trimester prenatal care began	Adequacy of prenatal care utilization					
	Intensive	Adequate	Intermediate	Inadequate	No Care	Missing
First	4.6 (6,085)	58.3 (76,815)	5.6 (7,439)	0.4 (581)		
Second	0.8 (993)		10.8 (14,293)	0.9 (1,154)		
Third	0.0 (58)			2.4 (3,146)		
Total	5.4 (7,136)	58.3 (76,815)	16.5 (21,732)	3.7 (4,881)	0.5 (645)	15.6 (20,636)

Table 3

Percentage low birthweight and preterm births by trimester prenatal care began and adequacy of utilization (1990-91 single live births to Minnesota resident mothers)

Trimester of initiation and adequacy of utilization	% Low birthweight	% Preterm
1st trimester prenatal care		
Adequate	2.96	5.48
Intermediate	6.95	12.23
Inadequate	7.75	13.25
2nd trimester prenatal care		
Intermediate	4.08	7.61
Inadequate	11.70	18.72
3rd trimester prenatal care		
Inadequate	3.78	7.66
No prenatal care	21.43	29.70
Missing	7.20	11.61
Total	4.19	6.89

attainment or a high parity for age (see definition in appendix) were at an increased risk of receiving inadequate prenatal care. American Indian women and married teens exhibited more than twice the risk of obtaining inadequate prenatal care as compared with women who were white, adult (18+ years), married, multiparous, of average parity for age, and of average educational attainment. High educational attainment, primiparity, and an age of 30+ years reduced the risk of inadequate use of prenatal care.

The second analysis selected women who started prenatal care in the second trimester and again sought to identify the socio-demographic characteristics associated with women who inadequately utilized prenatal care services thereafter. The risk characteristics were similar to those identified in the preceding analysis of women initiating care in the first trimester: age<18 years, not married, low educational attainment, and high parity for age. All ethnic groups other than white, i.e., black, American Indian, and other, exhibited twice the risk of inadequate utilization of prenatal care.

The third analysis compared women who received no prenatal care with women who received any prenatal care, without considering the trimester in which care was initiated. This analysis, focusing on predictors of no prenatal care use, revealed that unmarried adolescents and unmarried adults demonstrated nearly 10 times the risk of receiving no prenatal care as compared with married adults. Married teens did not have a significantly higher risk of receiving no prenatal care. Women with high parity for age were at three times the risk of receiving no prenatal care as compared with women of average parity for age. Ethnic minorities were more likely to obtain no prenatal care than whites.

Discussion

Although women receiving late or no prenatal care are of concern to the health care system, this investigation reveals another group needing attention: women who seek care early but fail to receive the recommended number of visits. While our data are insufficient to investigate possible underlying factors, such as service availability and cultural acceptability, they do indicate an area for future collaborative investigation by the public and private sectors in reproductive health care. Although this group of women is relatively small (N=581 in our study), it is important because it is a "known" group—the women appeared for care early in their pregnancies and only later were found to have received less than adequate care. Women who began care in the second trimester and also re-

ceived inadequate care may be of equal interest because the group is relatively large (N=1,154 in our study) and because its members are known, unlike those who never seek care.

Messages that encourage women to seek early medical care should also urge adherence to the prescribed regimen of care. Targeted outreach efforts designed to promote access to care should directly refer women to providers. All prenatal care providers should work cooperatively to follow up on missed appointments. For example, private clinics could refer to community health agencies women who fail to keep an appointment, as well as those identified as potentially benefiting from community health services and public health nursing support.

Medical care providers have yet another critical responsibility—improving the quality of data necessary for these types of analyses. Of the 131,845 cases available for analysis, 8.7% were missing data on the month prenatal care began; 6.6% were missing data on the number of prenatal care visits received; and 20.8% were missing the date of last normal menses, necessary for calculating gestational age. Even after extensive effort to impute estimates for missing values, we found it impossible to calculate prenatal care adequacy in 15.6% of the cases. Clearly, the level of missing data on live births is problematic. Women with missing data on the gestational age, the trimester prenatal care began, or the number of prenatal care visits exhibited low birthweight percentages that were more than double those of women with adequate prenatal care use. While there are other limitations to these data (for example, the prenatal record may be sent to the hospital up to four weeks before the delivery and, therefore, will contain incomplete data on the total number of visits), vital records remain the best source of population-based data on natality. The data are critical for state and local planning for public health interventions, as well as for health care reform initiatives intended to increase health care access and quality while minimizing further increases in cost.

Minnesota has aggressively sought funding to support the provision of prenatal care and related services to lower-income women since Congress expanded Medicaid eligibility in 1984. In 1993, the Minnesota Legislature authorized coverage of pregnant women and infants with incomes up to 275 percent of the federal poverty level under the state Medicaid (Medical Assistance) program. This equates to an annual income of $32,700 for a family of three. Medical Assistance will also reimburse perinatal providers at a higher rate for an expanded service package for women deemed to be at higher risk. This service package may include greater reimbursement for high-risk medical management and health education, including preterm labor prevention; counseling for such specific health concerns as alcohol, tobacco, or other substance abuse; nutrition education; care coordination; and a postpartum home visit.

Through Community Health Service Agencies, federal maternal and child health funds support improved pregnancy outcome efforts designed to meet community needs. These projects may offer public awareness and outreach, educational programs on various topics, home visiting, prenatal education classes, counseling, and postpartum services including family planning, if desired. Women eligible for Medical Assistance or MinnesotaCare or considered in need of ancillary services can be referred to the local community health service agency. Women can be referred directly to MinnesotaCare by calling 800/657-3672.

The Minnesota Department of Health is exploring strategies for improving the quality of reporting on birth certificates to assure the availability of complete and accurate data for analysis. This effort will rely on the cooperation and interest of private providers, as well as local community health service agencies. Widespread cooperation will be necessary not only to ensure quality care but also to facilitate the active and accurate monitoring of health status among pregnant and postpartum women across Minnesota. MM

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Appendix

The following table provides adjusted odds ratios with confidence intervals of receiving the less desirable level of prenatal care in each logistic regression analysis for selected maternal socio-demographic characteristics. The reference group for these analyses is white, adult (18+ years), married, multiparous women with average parity for age and average educational attainment. Odds ratios in excess of the value 1 indicate an increased risk of the less desirable level of care. Odds ratios less than 1 indicate the characteristic has as lower risk than the reference group. The 95% confidence intervals of the odds ratios are shown in parentheses. If the value of 1 lies within the confidence interval, the odds ratio may not be significantly different than the reference group.

Odds ratios and confidence intervals from logistic regression analysis of receipt and adequacy of prenatal care indicators (1990-91 single live births to Minnesota resident mothers)

Maternal characteristics	1st trimester <adequate vs. adequate	2nd trimester inadequate vs. intermediate	No care vs. any prenatal care
Teen (<18 years), not married	1.59 (1.34-1.89)	1.80 (1.33-2.44)	9.58 (6.60-13.90)
Teen (<18 years), married	2.40 (1.56-3.69)	1.60 (0.76-3.40)	1.13 (0.15-8.27)
Adult (18+ years), not married	1.57 (1.47-1.68)	1.63 (1.39-1.91)	9.92 (7.86-12.52)
Mother 30+ years of age	0.92 (0.88-0.97)	0.88 (0.74-1.04)	1.06 (0.85-1.32)
Primipara	0.65 (0.62-0.69)	0.52 (0.44-0.61)	0.62 (0.51-0.76)
High parity for age*	1.97 (1.69-2.29)	1.57 (1.26-1.96)	3.37 (2.62-4.34)
Low educational attainment†	1.37 (1.26-1.50)	1.63 (1.40-1.91)	1.45 (1.20-1.76)
High educational attainment†	0.80 (0.76-0.84)	0.75 (0.63-0.90)	0.73 (0.58-0.93)
Black	1.65 (1.45-1.87)	2.37 (1.95-2.88)	2.33 (1.87-2.90)
American Indian	2.78 (2.40-3.22)	3.63 (2.94-4.50)	1.74 (1.30-2.32)
Other race	1.85 (1.60-2.15)	2.52 (1.99-3.19)	1.84 (1.24-2.74)
Number	88,080	14,631	115,737

*High parity for age defined as 1 or more previous births for adolescents (<18 years), 3 or more previous births for mothers 18-21 years, 4 or more previous births for mothers 22-24 years, and 5 or more previous births for all other mothers.

†Educational attainment defined for adults (18+ years of age) as low (<12 years), average (12 years), high (>12 years); for adolescents (<18 years of age) defined as low (2+ years below expected grade level), average (within 1 year of expected grade level), high (2+ years above expected grade level).

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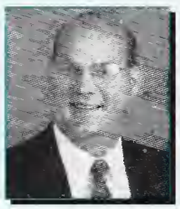

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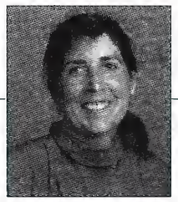

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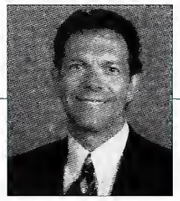

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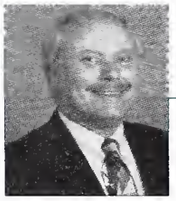

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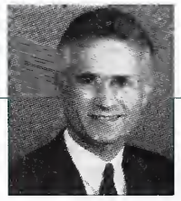

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The Inventive Physician

Doctors are a creative sort and often develop new medical ideas or inventions, but few know the ins and outs of patenting a product.

Philip M. Goldman, J.D.

Physicians, by their very nature, tend to be an inquisitive and creative lot. Given their diverse experiences and expertise, it is not surprising that this creativity often results in the development of new ideas and inventions in medicine. Most physicians probably believe they have, at one time or another, come up with a new or improved method of accomplishing some medical task. Very few, however, take the initiative to commercialize or even further develop the idea.

This article explores some basic principles underlying the protection and commercialization of new ideas and applies those principles to issues common to medical inventions. One area of particular importance is determining ownership of inventions, which often involves an assessment of the physician's relationship with partners, employers, universities, or outside companies.

Determining the Idea's Patentability

The form of protection that immediately comes to mind for new ideas is patenting. However, a number of requirements need to be met to patent an idea or invention. A first requirement is that the idea actually be of a patentable variety, as compared with ideas that are better protected by trademarks or copyrights. Briefly put, patents are best used for the protection of ideas that relate to new and useful "things," to methods of making things, to methods of doing or using such things, and to improved varieties of old things. These "things" can be visible or invisible, tangible or intangible, and as large as a stadium or as small as a new molecule or chemical formulation.

Trademarks, on the other hand, protect the name, symbol, or manner used to identify such things. The purpose of a true trademark is to help consumers distinguish products or services that embody a new idea from other products or services.

In contrast to both patents and trademarks, copyrights are used to protect the *expression* of ideas, rather than the ideas themselves. With a medical product, for instance, a copyright could protect aspects of its packaging or accompanying inserts, manuals, or software.

Assuming the new idea does, in fact, lend itself to patent protection, the inventor faces the initial hurdle of filing and then "prosecuting" a patent application through the patent office. The inventor will inevitably encounter the tripartite requirement that the idea be "new, useful, and unobvious."

The patent office frequently questions an invention's usefulness—otherwise known as "utility"—but rejections rarely stick. Most inventors, including physicians, are unlikely to spend their time or resources on something that is truly not useful. Still, the utility requirement perhaps finds its greatest application in the medical field, particularly when the utility of a material or method is merely speculative, or as yet unproven. An example of an invention that would face stiff opposition based on utility would be a cure for cancer or AIDS. Although the standard for patent utility is far lower than the efficacy standard imposed by the FDA or by consumers, the patent standard can still be significant.

Another requirement for patentability is that the invention be new. This essentially means that the invention, as claimed in the application, has not already been described or disclosed in "prior art," which often includes the relevant patent and scientific literature describing the work of other investigators.

Just as likely, however, prior art can include acts and disclosures made by the inventor himself. The patent system is intended to encourage the disclosure of inventions as early as possible. As a result, the government is willing to grant an inventor a limited monopoly around the invention in exchange for a full and prompt patent disclosure. It follows, therefore, that if the inventor is willing to disclose the invention without such a grant—such as by publishing or marketing the invention—the government no longer has any justification for granting a patent. If an inventor sells, publishes, or otherwise discloses the invention before filing a patent application, he creates prior art against his own invention.

The last and often toughest hurdle for patentability is obviousness.

The word is a bit of a misnomer, having a legal meaning established by statute and case law that goes well beyond what might first come to mind. When applied to inventions, obviousness is determined by comparing the invention with the prior art. Volumes of case law and statutes can be relied upon to answer the somewhat subjective question of whether the invention provides "unexpected" properties or results in view of that art. Foreign patent offices often refer to the same concept as an "inventive step" in the invention's creation.

Most patent applications encounter at least one obviousness rejection over their course, and such rejections often become the main battleground in determining whether a patent will ultimately be granted.

Resolving Ownership Issues

Assuming that the physician has, in fact, made or contributed to the making of an invention, the next issue commonly encountered, particularly in medicine, is ownership of the invention. As a starting point, unless the inventors have signed agreements to the contrary, the law states that each inventor will be an equal owner of the invention. This is true regardless of the type or scope of the inventors' respective contributions. In turn, each will have the right to exploit that invention, either alone or with others.

Prior agreements dealing with ownership, however, are often the rule rather than the exception. An inventor's ownership rights can be transferred to others in the form of either assignment or license. In many respects, the differences between assigning and licensing a patent or invention are akin to the differences between selling and leasing a car. The seller of a car determines a single price for which he will relinquish all ownership rights in the car. The lessor of a car, however, merely agrees to allow the lessee to use the car for a predetermined time and in a prescribed manner. At the end of the lease period, or if the lessee fails to perform his end of the bargain, possession of the car returns to the owner. The situation with patents is similar in that inventions and patents can be assigned—sold outright—or they can be licensed. In the case of assignment, the patentee generally receives payment up front and transfers all ownership rights to the buyer. In the case of a license, however, the licensee is provided with only limited rights to the claimed invention, while the patentee retains all other rights pertaining to ownership. Retaining ownership, for instance, would mean that the patentee would continue to control the patent application and maintenance process.

> "A number of requirements need to be met to patent an idea or invention."

The biggest difference between the car and the patent is that inventions can be assigned or licensed prospectively, that is, before they arise. In other words, a potential inventor can (and often does) commit herself to assign or license an invention even before that invention comes into being. An employee agreement, for instance, will often require the assignment of inventions. A consulting agreement might also require either the assignment or license of any inventions that arise in the course of the consultant's efforts.

In a similar vein, and again of particular importance in the medical area, are pre-existing obligations made in the course of obtaining federal grants or other sources of funding. Also affecting rights to an invention are agreements or understandings between the members of a physician's own practice group, or between the physician and the employees or students who collaborated on the development of the idea.

Understanding and dealing with these pre-existing obligations can be critical, since the path the physician takes to further develop or commercialize an invention needs to be consistent with all such prior obligations. Just as a car owner cannot lease a car to a second party if it has already been leased to another, an inventor may not be able to provide others with rights to an invention, or even use those rights herself, if they have been preordained.

Even when a physician inventor clearly has not signed away rights, she may still be required to provide rights to her employer. This can arise under a legal doctrine known as "shop right," which is now codified in many states, although not Minnesota. This common law doctrine establishes factors used to determine whether an employer may have rights to an invention made by an employee in situations where patent ownership is not addressed in a prior employee agreement. The factors consider how closely the subject matter of the invention compares with the business of the employer; the type and extent of the employer's facilities, equipment, and overhead used in the course of making the invention; the job responsibilities of the inventor/employee; and so on.

Conclusion

This is but a brief overview of protection and ownership issues that can arise in the course of medical invention. Although the topic can seem complex, and the process perhaps daunting, the prudent physician will take the time and effort to settle these issues. The more commercially successful an invention becomes, the more likely it will be that others will someday question and scrutinize ownership. A new product idea that is otherwise worthy may be jeopardized if it relies on a weak infrastructure of protection and ownership. MM

Philip Goldman is an officer with the law firm of Fredrikson & Byron, P.A., in Minneapolis, practicing in the areas of intellectual property law and technology transfer, with a focus on the biomedical arts.

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CHRISTENSEN

(continued from page 7)

our EMS systems as well as home health care. EMS is the backbone of rural care."

Many communities would argue that hospitals are essential not only for health care, but also as a major component of a town's economic base—sometimes the *only* component. Christensen's response: "Is it the responsibility of the health care system to keep a community alive, or is it the responsibility of the health care system to deliver care?"

Christensen also advocates subregionalization as an important aspect of reform. "My fight over the years has been to provide access to rural residents. I long ago learned that doesn't mean a doctor in every town. It means a good EMS system. It means six or eight doctors practicing together in a central location in a practice attractive to the young providers of today. Pool the risk. Keep the skills and quality up. A larger clinic keeps the call system manageable."

One significant benefit of creating larger, centralized clinics, rather than maintaining several solo and small practices throughout a region, is that it helps attract and keep doctors. Physicians need to talk together, says Christensen. And they need back-up for vacation. "Family and recreation come before the practice. It may be sacrilegious to say that, but if we want to keep physicians from burning out and keep them interested in primary care in rural areas, then we must provide time for travel, family, and recreation," he says.

For Christensen, such time is critical—time with his wife, Rita, whom he's known since grade school and started dating at 18, and with their two daughters, Kari and Anna, both in college now. "Ray is very much a family man," says Terry Hill, Christensen's colleague at the Center for Rural Health. "The amazing thing is that, even though he's busy with so many organizations, he always has time for his family." Recreation is also important to Christensen, who has competed in 13 marathons and several bike races. Why live in beautiful northern Minnesota and not enjoy it, he asks, calling Lake Superior a "source of life."

Christensen grew up in rural Wisconsin, the oldest of six children on a small dairy farm, where the seeds were sown for his intense interest in health care access. "We had no health care insurance and knew that any disaster could destroy the family business." Christensen didn't consider medicine until after obtaining his degree in agriculture at the University of Wisconsin, River Falls. He always knew he wanted to earn a "decent living" in a small town and initially considered veterinary science. But the agriculture school dean encouraged him to consider medicine.

> "If we want to keep physicians from burning out, we must provide time for family and recreation."

Christensen describes himself as a "conservative farm boy with a mean liberal streak," which he obtained while attending medical school in Madison. "I went to school during a time of social upheaval [1967 to 1971]. Students were destroying the campus protesting the war; meanwhile, my younger brother was in the jungle with a machine gun. The youth of America were strongly addressing society. Through that, I realized the power of the people." Thus, Christensen's involvement in the fight for health system reform.

Of all his roles in health system reform, Christensen says the most important is the practice of family medicine. "It keeps me in touch. It's the only way to get a grassroots feel for the changes that are taking place and what's going on with the people I care for. It gives me a perspective to bring to the table."

But the Minnesota Health Care Commission, the group that advises the state Legislature on implementing MinnesotaCare, takes a close second place. As the rural physician representative on the commission, Christensen has the opportunity to help formulate reform through MinnesotaCare. "I'm not sure there's any other place where you have that kind of input. You have a chance to influence the Legislature, a chance to collaborate with leadership."

And Christensen's voice is certainly heard on the commission. "The members truly respect him," says Robert Kelly, M.D., a former member of the commission. "He understands the problems of rural patients and physicians. He's very knowledgeable in his field."

When asked if MinnesotaCare is heading in the right direction for rural Minnesota, Christensen's reply is quick and clear. "Absolutely. I think we have an excellent system in our state. We need to look at what's unique and make it better. And that's not Canada; it's not Germany or the Netherlands; and it's not England or Japan. There might be a flavor from each, but we are a unique country driven by different values, and that has to be recognized. Reform requires a debate, and that's happening. Minnesota is several years ahead of other states."

Christensen's efforts with dozens of organizations are aimed solely at improving rural health care, says Kelly. His dedication led him to receive the Louis Gorin Award for outstanding achievement in rural health care from the National Rural Health Association in 1989. "Christensen's No. 1 concern is patients of rural physicians, and his No. 2 concern is how rural physicians can best deliver care and still maintain their sanity," says Kelly.

All in all, Christensen says, never has more attention been paid to rural health care. Whether good or bad, change is on its way. "Communities need to be ready to move. I'm finding that as we work with ISNs and CISNs, the rural communities think this reform is stuck in the Legislature and will never come. But it is coming. Society is directing this change, and it's going to go on." MM

Susan Rodsjo is associate editor of Minnesota Medicine.

Ethical Physicians Cannot Serve Two Masters

C. Randall Nelms Jr., M.D.

The AMA Principles of Medical Ethics state that physicians are ethically bound to deal honestly with their patients. It is unethical to provide, prescribe, or seek compensation for services that are known to be unnecessary or worthless.

Physicians' actual performance has not always conformed to the ideal, but when there were doubts in the past about a doctor's behavior, at least there was little doubt about what the behavior ought to be.

What's different today? Policymakers, patients, managed care administrators, ethicists, and physicians, each for their own reasons, are promoting concepts of how physicians should act, and their ideas are often at odds with traditional ethical principles. Policymakers want physicians to be gatekeepers of society's resources and instruments of the bureaucratic machinery. Patients desire absolute autonomy and see physicians as instruments of their wishes. Administrators of managed care systems want physicians to be entrepreneurs, competitors, and instruments for their profit. Ethicists want physicians to substitute a contractual arrangement for a fiduciary model of the physician-patient relationship. In the old days, physicians had no doubt that the patient's well-being was the utmost concern. Today, our professional vision is clouded.

Who can blame physicians for being depressed, cynical, and hostile? Some doctors are retiring early, and others are seeking acquisition and employment. But some compromise with actions that make them morally uncomfortable.

Why should physicians and other health professionals maintain standards of moral behavior when society permits or even encourages less constraining moral attitudes? Because an honest relationship between the ill patient and the physician—who professes to help and heal—is crucial to providing health care. Ill patients are vulnerable and forced to trust us. Without their trust, proper health care is jeopardized. Patients may look closely at our credentials, our reputations, and our performance, but at some point, they must trust us. We have a responsibility to protect their interests and ultimately to earn their trust.

"An honest relationship between the ill patient and the physician—who professes to help and heal—is crucial to providing health care."

Physicians' moral obligations are many: to treat patients with HIV infections; to conduct peer review; to promote preventive medicine and healthy behaviors with respect to smoking, diet, exercise, drugs, alcohol, and seat belts; to care for the poor and homeless; and to help increase access to health care, for example.

Physicians must safeguard patients' well-being. We cannot be double agents. We either primarily serve the patient, or we primarily serve ourselves, the hospital, the fiscal policy, or the law.

Is it possible to be an ethical physician today? Is it possible to be faithful to the moral requirements of the physician-patient relationship? Or to survive in a world in which the pursuit of self-interest is dominant and even legitimized?

Physicians can be moral, but they cannot be expected to meet their obligations single-handedly. We need support from the community. We are well aware of the outside forces that negatively affect medical care: for example, the malpractice crisis, the burden of regulatory policies and meaningless paperwork, the primary focus of insurance carriers and corporations on the bottom line. We must consider how these forces affect those we serve. We must demonstrate that our first concern is our patients' welfare. We must convince the public and legislators that the commercialization of medicine is unjust and damaging to the welfare of the sick. We must influence the public, government, and industry to reassess their values and to recognize that the pursuit of happiness is impossible without health and medical care for all citizens.

The challenge we face today is to choose between two opposing views, one of self-interest and one of obligation to our patients. A great deal is demanded of us, but, yes, we can be ethical in today's practice climate. MM

People and Places Making Medical News

People

'U' Health Sciences Provost

William Brody, M.D., Ph.D., currently chair of the radiology department at Johns Hopkins University in Baltimore, has been named provost of the University of Minnesota academic health center effective September 1. The new position was created after recent controversy and scandal surrounding the university's medical school. At Johns Hopkins, Brody is in charge of a $65 million budget and staff of 500. In his new post, he will oversee six colleges, 9,000 employees, and budgets totaling $750 million. Brody's $290,000 salary is nearly twice that of University President Nils Hasselmo.

UMHC General Director

Peter Rapp, currently chief operating officer of Medical College of Virginia Hospitals, has been named general director of the University of Minnesota Hospital and Clinic. As *Minnesota Medicine* went to press, the University of Minnesota Health System's Board of Governors was expected to approve his appointment at its June 22nd meeting. Rapp is expected to begin his duties August 15.

Woman Physician of the Year

St. Paul-Ramsey internist **Patricia Walker, M.D.**, has been named Minnesota Woman Physician of the Year by Alpha Epsilon Iota, a national medical fraternity for women. Walker is lead physician at Ramsey's International Clinic for non-English speaking new Americans and trains other physicians in cultural competence.

Outstanding Women Students

Four outstanding medical students have each been awarded $1,000 grants by the Minnesota chapter of Alpha Epsilon Iota Medical Fraternity for Women. **Robin J. Baker, Jacalyn A. Dahl**, and **Jennifer L. Merchant** are from the University of Minnesota Medical School, and **Kellie Kershisnik**, attends the Mayo Medical School.

Fairview VP of Medical Affairs

Gordon L. Alexander Jr., M.D., has been named senior vice president of medical affairs for Fairview Health System. Alexander left private practice as an obstetrician and gynecologist at Southdale Obstetric and Gynecologic Consultants, P.A., to assume his new position at Fairview.

PPN Physician Director

Chris Johnson, M.D., of Mound Medical Clinic, has been appointed physician director of Primary Physician Network (PPN), an affiliation of five primary care clinics and HSM Associates. PPN doctors represent 10 locations and 30 primary care physicians who practice at Methodist Hospital in St. Louis Park.

Garfinkel Stops Research Permanently

Barry Garfinkel, M.D., the University of Minnesota psychiatrist convicted of research fraud last year, has agreed to put in 1,000 hours of volunteer work and to give up drug research permanently in a settlement with the Minnesota Board of Medical Practice. The board in return agreed not to revoke Garfinkel's license to practice medicine. His research fraud conviction has been appealed to the U.S. Circuit Court of Appeals.

New CFO at HCMC

Hennepin County Medical Center has named **Roger Balagot** its new chief financial officer. Balagot was former CFO at the University of California-Irvine Medical Center in Orange, California.

New Medicaid Director

Katherine Cairns has been named assistant director of Medica's Medicaid Department. Cairns was previously public health director for the city of St. Paul.

HealthSystem Head Retires

HealthSystem Minnesota has announced that **Robert Galloway**, president and chief administrative officer, plans to retire. Galloway has not set a specific date for retirement as of yet. HealthSystem Minnesota, parent company of Park Nicollet Medical Center and Methodist Hospital, was formed a year ago and has announced plans to restructure.

Places

St. Francis and Park Nicollet Building Hospital

St. Francis Regional Medical Center and Park Nicollet Medical Center are collaborating to build a hospital and outpatient facility in Shakopee on County Road 17. The plans for the new medical campus include a new facility for ambulatory care and hospital services for St. Francis called Park Nicollet Shakopee Clinic, and a medical office building to house independent physicians. The new campus will be built on a 60-acre site and is estimated to cost between $8 million and $12 million. Building is scheduled to begin early next year.

Fairview Begins Construction on Apple Valley Clinic

Fairview Health System is planning construction of a $2.2 million medical clinic in Apple Valley to serve residents in the Apple Valley-Lakeville area. The clinic is expected to be completed in November.

The clinic will be staffed by a

core of family practice physicians who treat infants, children, and adults for acute and chronic illnesses. It will also provide maternity care and obstetrical services.

HealthPartners Building Surgery Center

HealthPartners has announced plans to build a surgery center in St. Paul, which will be the first free-standing center in the state owned by a health plan. The center is expected to open in September and will offer a variety of surgical procedures. HealthPartners also became the first health plan to own a hospital when it signed a merger with St. Paul-Ramsey Medical Center last year.

St. Paul-Ramsey Begins Reconstruction

St. Paul-Ramsey Medical Center has begun work on a $7.2 million reconstruction of the hospital's emergency center. The new center, expected to open in August 1995, will be a three-story, 25,000 square-foot addition to the hospital. This is the first large-scale renovation of the medical center in almost 30 years.

St. Cloud Hospital and Mayo Develop Residency Program

St. Cloud Hospital and the Mayo Graduate School of Medicine have collaborated to develop a fully accredited family practice residency program in St. Cloud. The three-year residency program will be geared to graduates interested in rural practice, will begin in July 1996, and will accept just four residents each year.

Socioeconomics

PreferredOne Plans New HMO

PreferredOne, a Minneapolis-based preferred provider organization, is forming a new health maintenance organization that it hopes will be operational by January 1, 1995. PreferredOne is owned by Minneapolis-based Fairview, North Memorial Medical Center in Robbinsdale, and PreferredOne Physician Associates, a 1,500-member physician group. Marcus Merz, president and chief executive officer of the PPO, said the change is a first step toward establishing an integrated service network.

MHCC Backs Use of Heart Attack Drugs

The Minnesota Health Care Commission accepted a report in May stating that doctors should use clot-busting drugs more often to treat heart attacks but should keep in mind their potentially staggering cost. The commission is disseminating the recommendation to health care providers.

In considering the cost difference between streptokinase ($300 per dose) and t-PA ($2,300 per dose), the commission decided not to recommend use of one drug over the other. The commission said t-PA seems to have a slight advantage in increasing chances of survival over streptokinase for clots in the front of the heart or when clot-dissolving drugs are given within four hours after symptoms begin. However, t-PA is also associated with an increased rate of stroke. The report notes that spending the extra $2,000 for t-PA may be justified for certain patients, but the commission urged physicians to consider cost when treating patients.

The commission said that physicians who specialize in treating heart disease are familiar with the risks and benefits of the two drugs, but other physicians may not be familiar with the studies. The report's intent is to give these physicians information.

For more information on the commission's report, see *The Monitor*, page 33.

MCMC Lays Off Workers, Despite Deal With Governor

Minneapolis Children's Medical Center laid off 236 part-time and full-time employees as of July 1 as part of a plan to save $6.25 million during the final six months of the year. The hospital said it was forced to make cuts because of shortfalls in Medicaid reimbursement, discounts demanded by health plans, and the trend toward reduced use of hospitals. About half those laid off are nurses, respiratory technicians, and nurse anesthetists. The balance involves nutritionists, social workers, and personnel in support services, administration and management, housekeeping, marketing and communications, accounting, and human resources.

The hospital's plan to cut costs also includes reducing the number of staffed beds from 163 to 149; capping the home care program at current levels; reducing the hours at a clinic the hospital has for teenagers at Southwest High School; closing an urgent care clinic; and consolidating three medical/surgical units into two.

The hospital announced in April that it planned the layoffs, totaling 187 full-time positions, because it appeared it would have to repay the state $5.2 million under a retroactive change by the state in Medicaid reimbursement. The Legislature voted to reduce the debt through the Omnibus Health and Human Services Bill, but Gov. Arne Carlson vetoed the proposal. After heavy criticism, Carlson later postponed the Medicare cuts until July 1995 as part of an agreement with local hospitals, but Minneapolis Children's decided to go ahead with the layoffs because it still expects reductions in Medicaid income and losses from insurance discounts.

Carlson's veto threatened the viability of other hospitals, as well, including Gillette Children's Hospital and others with a high percentage of Medicaid patients. However, Carlson's agreement seemed to satisfy local hospitals. He and local hospitals will attempt to work out an administrative solution to the long-term Medicaid funding problem before the 1995

legislative session begins. In addition, the governor will delay until July 1, 1995, planned cuts in hospital Medicaid reimbursements; he and his staff will try to find additional ways to cut the state's health care expenses, taking pressure off the Medicaid program; and the governor's administration will try to persuade the federal Health Care Financing Administration to grant Minnesota special pilot project waivers that will enable the agency to increase federal Medicaid reimbursement rates to the state's hospitals.

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AMA Proposes Patient Protection Plan

The American Medical Association, together with Minnesota Sen. Paul Wellstone, has drafted legislation called the Patient Protection Act that would require health plans to 1) make public the standards used to hire physicians, 2) protect physicians from arbitrary decisions to leave them out of a network, 3) give people more information about insurance plans before they sign up, and 4) guarantee health plan choices. The intent is to give physicians and consumers the information they need to make informed decisions and to expand their array of choices.

"Insurance companies are out to protect their bottom line, no matter what it does to patient care," said Lonnie Bristow, M.D., chair of the AMA's Board of Trustees.

Wellstone is offering the AMA proposals as amendments to other health reform legislation. (For further information, see *The Monitor*, page 33.

Medical Research

NCI Testing 'U' Resident's Cancer Therapy

The National Cancer Institute began trials in May of a powerful anticancer therapy developed by 35-year-old University of Minnesota surgery resident Mark Saxton, M.D., who has been on leave for the past three years to work at NCI's immunology laboratories in Frederick, Maryland.

The therapy involves beefing up T-helper cells that direct killer cells to attack and destroy cancer cells. "Most previous research has centered on activating killer cells themselves, but many researchers now think it appears that it's better to go back a little further, to the helper cells ... [and let the body] defend itself more naturally," said Saxton.

The cancer institute plans to recruit 33 cancer patients with terminal or advanced solid tumors such as lung, liver, colon, and kidney cancer, to see if the therapy is safe and effective.

AIDS Update

Committee Recommends Approval of AIDS Drug

An FDA committee recommended approval of a new AIDS drug, Stavudine, but strongly warned that doctors don't know enough about the drug to say who should take it. The panel said the drug, known as d4T, probably provides some benefit over the three existing AIDS drugs, but the panel doesn't know just who would benefit, how safe it is, or whether the manufacturer will soon be able to answer these questions.

The FDA is considering whether to permit the sale of d4T under a special procedure that allows a company to sell a drug that may offer relief for a life-threatening disease before the company proves definitively that the drug works. Permission would be revoked if the maker doesn't meet FDA conditions.

Salk Group Testing Killed-Virus AIDS Vaccine

Colleagues of Jonas Salk, the scientist who discovered the polio vaccine, announced in June plans to start large-scale trials of a killed-virus AIDS vaccine. In a research report in the *Journal of Infectious Diseases*, the group said growth of HIV slowed substantially in infected volunteers given three injections of the vaccine.

Some researchers have feared that killed-virus vaccines could be dangerous because they might activate infected immune cells and cause them to spill out quantities of the deadly virus, accelerating disease progression. Salk's colleagues said in a Boston interview that their first round of experiments, involving about 300 HIV-infected patients, should put that fear to rest. The 79-year old Salk has argued since 1986 that the best way to thwart HIV is to stimulate an immune response to the whole virus after it has been killed with chemicals and radiation so that it is no longer infectious.

The researchers plan to recruit 4,000 or more patients for studies in up to 40 medical centers. They hope to win Food and Drug Administration approval for the trials by the end of this year. MM

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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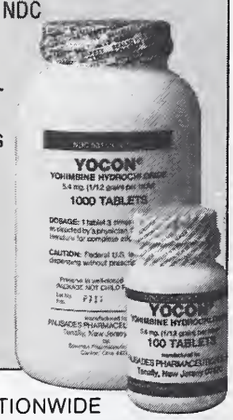

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JULY 1994

July 7-9 **Chronic Lymphocytic Leukemia** Mayo Medical Laboratories; Silverado Country Club and Resort, Napa, CA. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

July 11-15 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.

July 14-15 **Advanced Pediatric Life Support** Hennepin County Medical Center; Hennepin County Medical Center, Minneapolis, MN. CONTACT: Rachel Knudson, R.N., EMS Training, Hennepin County Medical Center, 701 Park Avenue South, Minneapolis, MN 55415; 612/347-3638.

July 15-16 **Gynecologic Cytology** Mayo Medical Laboratories; Harold W. Siebens Building, Rochester, MN. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

July 22-24 **The Challenge of Spine Care Management** Minnesota Spine Center; Arrowwood Resort, Alexandria, MN. CONTACT: Beth Cant, Minnesota Spine Center, 606-24th Avenue South, Suite 606, Minneapolis, MN 55454; 612/672-6685.

July 25-29 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.

AUGUST 1994

August 1-5 **Psychotherapeutic Strategies with Borderline Patients • Treating Survivors of Incest and Abuse • Advance Topics in Neuropsychological Assessment and Treatment** Psychotherapy Center at Columbia Hospital and the Department of Psychiatry at the Medical College of Wisconsin; Egg Harbor, WI. CONTACT: Carlyle H. Chan, M.D., Summer Institute Director, Psychiatry Department, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, WI 53226; 414/257-5995.

Aug. 4-7 **Annual Scientific Conference of the Philippine Minnesotan Medical Association** HCMC/HFA Office of Academic Affairs/U of M; The Breezy Point Resort, Breezy Point, MN. CONTACT: Ann Samways, CME Coordinator, 612/347-2078; or Robin Hoppenrath, Manager, Office of Academic Affairs, 612/337-7128.

Aug. 5-6 **Bleeding and Thrombosing Diseases** Mayo Medical Laboratories; Harold W. Siebens Building, Rochester, MN. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Aug. 22-Sept. 2 **Twelfth Annual Occupational Health and Safety Institute** St. Paul-Ramsey Medical Center; University of Minnesota, Mayo Building, Minneapolis, MN. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

SEPTEMBER 1994

Sept. 9-10 **Disaster and Hazardous Materials Management Conference** HCMC/HFA Office of Academic Affairs/U of M; location to be announced. CONTACT: Ann Samways, CME Coordinator, 612/347-2078; or Robin Hoppenrath, Manager, Office of Academic Affairs, 612/337-7128.

Sept. 12-13 **Pediatric Emergency Medicine Course** HealthSpan; United and Children's Hospital Conference Center, St. Paul, MN. CONTACT: Annette Carlson, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7910.

Sept. 12-14 **The Norwegian-American Orthopaedic Society** Mayo Foundation; Siebens Medical Education Building, Rochester, MN. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME and International Education, 200 First Street SW, Rochester, MN 55905; 507/284-2509.

Sept. 15-17 **Practical Surgical Pathology** Mayo Medical Laboratories; Harold W. Siebens Building, Rochester, MN. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Sept. 22-23 **Domestic Violence** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Sept. 22-23 **Fourth Annual Practical Pediatrics for the Primary Care Physician** Children's Hospital of St. Paul; Children's Hospital, St. Paul, MN. CONTACT: Mickey Starr or Janet Salmey, 345 North Smith Avenue, St. Paul, MN 55102; 612/220-6109.

Sept. 23 **Contemporary Issues in Hemodialysis** HCMC/HFA Office of Academic Affairs/U of M; Sheraton Midway Hotel, St. Paul, MN. CONTACT: Ann Samways, CME Coordinator, 612/347-2078; or Robin Hoppenrath, Manager, Office of Academic Affairs, 612/337-7128.

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Practical Strategies in the Evaluation and Management of the Geriatric Patient: September 8-9, 1994; Holiday Inn Homestead, U.S. Highway 51, Minocqua, Wisconsin. Contact Marshfield Clinic, Office of Medical Education, 1000 North Oak Avenue, Marshfield, WI 54449; 800/541-2895. 2-7/94

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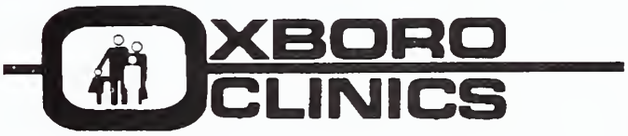

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Will Computers Become Tools of Our Trade?

Charles R. Meyer, M.D.

Medical education is like a shopping trip to a good hardware store. In medical school, internship, and residency, we acquire tools—physical, mental, judgmental—with which we ply our trade. Technology daily adds tools to our work belt. However, until recently, one tool long adopted by most other industries has been excluded from clinical medicine—the computer. It's been in the clinic business office, the hospital registration and billing system, and the research lab. But it has barely nudged into view in most clinicians' daily practice. The promoters of computers in clinical medicine promise efficiency, economies, and excellence. Skeptics envision frustrated physicians, failed fail-safes, and misguided guidelines. This *Minnesota Medicine* explores why the computer has not been physicians' tool of choice.

Our cover story this month scans the spectrum of computer applications in today's medical world and introduces us to medical informatics, the discipline of computer applications in medicine. A Special Report by John Levitt, M.D., analyzes why physicians have been so slow to make computers a tool of their trade and speculates whether they ever will. Among Levitt's concerns are patient confidentiality and the security of the electronic record, which are expanded upon in this month's Medicine Law & Policy article. Paul Carpenter, M.D., describes a national project, the Computer-Based Patient Record Institute, which sprang from an Institute of Medicine challenge to incorporate computerized medical records into the practice of medicine. And I tell the tale of the Harvard Community Health Plan's Burlington Clinic, which has used a computerized medical record for three years.

"Computers need to prove that they enhance productivity. No electric screwdrivers would sell if they didn't drive screws faster than hand screwdrivers."

Will computers help clinical practice, or are they destined to go the way of stomach freezing? The tool analogy helps answer this question. Any computer guru worth her chips will tell you that, indeed, the computer is *only* a tool. Herewith, I offer my prescription for non-dyspeptic assimilation of computers by medicine: 1) Like any tool, the computer has to be available. If computers sit in back rooms away from the people who are supposed to use them, they will gather more dust than all the old hula hoops in basements everywhere. Computers need to be located where doctors work if they are to use them. 2) Like tools, computers need to prove that they enhance productivity. No electric screwdrivers would sell if they didn't drive screws faster and more efficiently than hand screwdrivers. If computers add steps or frustration, they are doomed to fail. 3) The users of tools and computers need to learn how to use them; for both, the quicker the learning curve, the better. 4) Both tools and computers need standards that are shared by users. Tools come in both metric and non-metric standards, causing irritation and confusion among users. To avoid such frustrations, we need concrete standardization for computers.

Are computers a tool of the future for medicine? Will physicians join the digital revolution? I believe so. As practitioners, we need to keep as open a mind about computer use as we did about CT and MRI scans or, for that matter, as we did about histories, physicals, and problem-oriented records when we were in medical school. As with CT and MRI, we don't need to know every bit and byte that make computers tick. We only need to know how to use them at our own level. They can become as integral to our days as the H&P, but not without a little effort on our part.

What do we do during the course of a day that we could do better? That is but one of the questions needing an answer before computers can be incorporated into clinical medicine. And perhaps it is more important than the more erudite-sounding considerations of quality medical records, access, and outcomes measurement. Because, if the computer doesn't fit into the work flow of the people doing the work, the computer-based patient record and other medical computer applications will not sell; they will merely languish in the landfill of good ideas. MM

PIONEERING THE NEUROSURGICAL FRONTIER

Neurosurgeon Mary Dunn relies on space-age computer technology and a sixth sense to pinpoint and remove invasive tumors—cost-effectively.

By Fran Miller Toubin

Except for the pewtered cowboy boots from her childhood, all the art in Dr. Mary Dunn's office was given to her by patients or their children. "Thank you for making my mommy better," reads one brightly colored banner prominently displayed on the wall. It is a vivid testament to Dunn's primary motivation as a neurosurgeon and medical director of the Neuro-Oncology Institute at United Hospital in St. Paul: helping patients lead meaningful, productive lives.

Today, with the benefit of what some deem "Star Trek technology," Dunn and her colleagues are literally on the cutting edge of neurosurgery. Through the integrated use of functional cortical brain mapping, robotic microneurosurgery, and computer-generated three-dimensional imaging of a patient's brain and tumor (based on CT scans, MRI, and other tests), these surgeons are now able to remove more of a patient's tumor without damaging neurologic function, thus enabling patients to live longer, higher-quality lives. According to Dunn, the side-effects of this multidisciplinary approach being pioneered at United are lower costs and shorter hospital stays, providing proof that quality and cost containment in health care can coexist.

The neuro-oncology team pulls specialists from a variety of fields in addition to neurosurgery and oncology, including neuro-radiology, neurology, angiography, and neuro-physiology. Dunn, an Omaha native who received her medical degree from Creighton University Medical School before completing her neurosurgery residency at the University of Minnesota, explains that although the technique requires more scans and information-gathering sessions, once the information is put together, the actual costs are about 30 percent less than with conventional brain surgery.

"With this computerized system, we have many patients whose average length of stay is three days, a decrease of almost 50 percent," she says. "And then there are the indirect costs, such as time away from work, which are definitely lower than with conventional surgery." Dunn points out that the traditional approach to treating tumors that have invaded areas of the brain thought to control vital function is to do a biopsy to determine what type it is, perhaps remove a small percentage of the tumor, and then administer radiation or chemotherapy. At United, patients with these types of tumors or those who need epilepsy surgery undergo mapping, which involves surgically placing on the brain an 8cm by 8cm grid embedded with 64 small metal electrodes.

Small electrical currents are then applied to determine which electrodes stimulate various motor functions, such as speech or

PHOTOGRAPH BY BRUCE BAKER

"Computers have revolutionized our ability to take care of patients."

–*Mary Dunn, M.D.*

movement of the arms and legs. The mapping technique can be used to pinpoint functions down to the small movements of a certain finger, so surgeons know exactly how far they can go before damaging neurologic function, says Dunn.

After mapping is complete, results of this and scores of other tests and scans are fed into a computer, enabling it to generate three-dimensional images of the patient's brain and tumor, which are then used to guide surgical instruments and the surgeon's hands when removing tissue.

"Computers have revolutionized our ability to take care of patients," says Dunn. "Although stereotaxis—the re-creation of the brain in three-dimensional space based on norms—has been around since the turn of the century, the relatively recent technologies of the CT scan and MRI have finally come together so that the computer can not only image the brain, but also can help us operate based on those images by providing boundaries for tumors and other pathologies where the human eye is indistinct," explains Dunn. "We can now apply surgical technique to those areas of the tumor that are resectable—and that we should resect—and spare those areas in the perimeter that might be functional and need to be preserved." Dunn says that although other medical centers do mapping and computerized resection, United's Neuro-Oncology Institute is the first in the country to bring those two techniques together.

"We do this through an optical reading system and common reference points, bringing in information from blood vessel tests, CT scans, MRI mapping, etc.," says Dunn. "This pool of information is all cross-referenced by standard external points so you can project all images, one on top of the other. Technically, I can come within one millimeter of the border and preserve neurologic function."

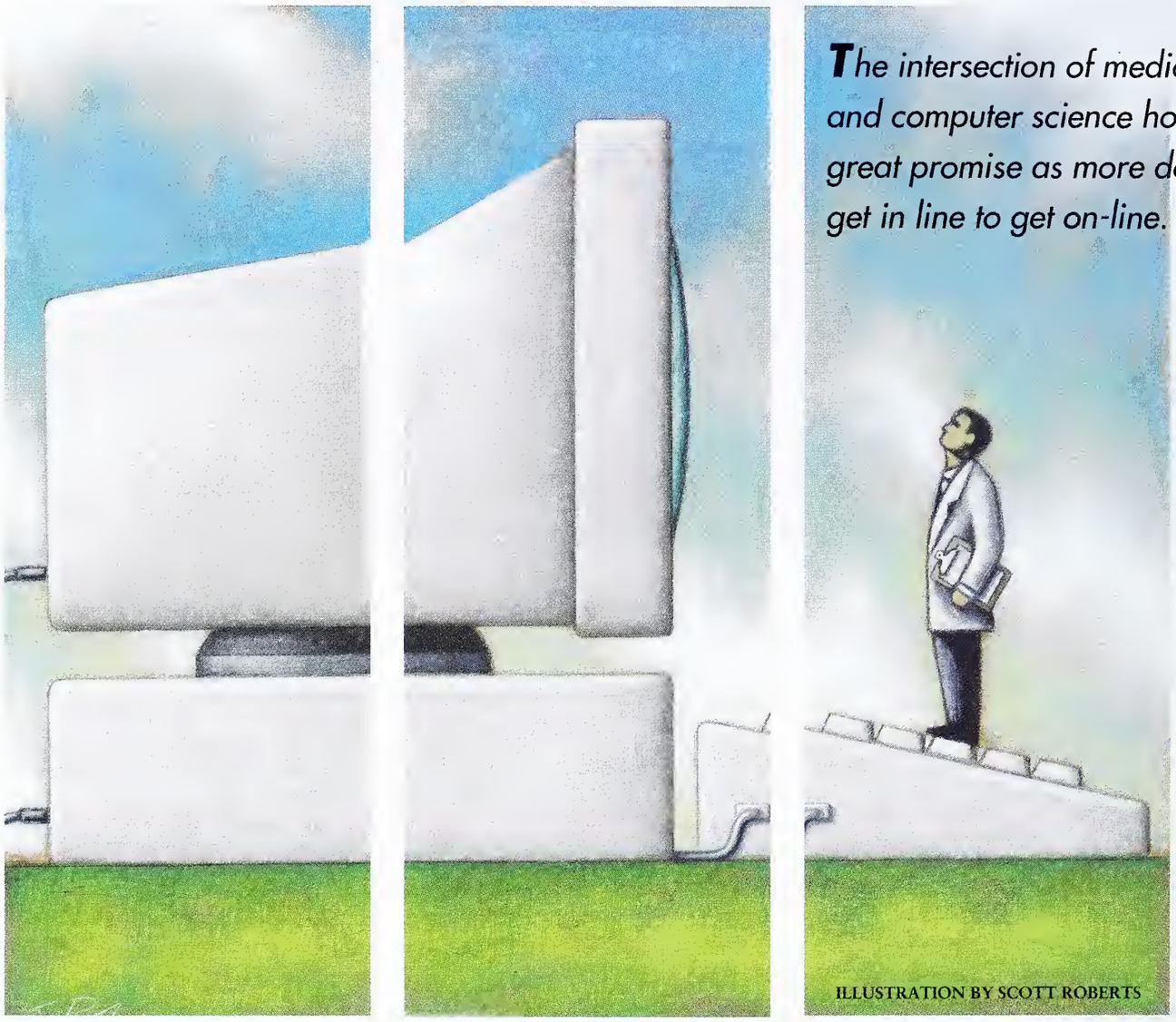
"We can then take this information to the patient so that he or she can weigh the risks and benefits of different percentages of tumor removal," says Dunn. "We might say, for example, that removal of 70 percent of the tumor will mean you will probably live longer but will lose your ability to speak. Sixty percent resection, however, may buy you 10 years, based on averages, and you'll be able to return to work in two weeks. When patients can enter into the decision-making process and know what to expect, fear and anxiety are reduced and rehabilitation is much easier. I firmly believe that one's emotional state affects recovery and longevity," she says.

Dunn says a recent finding by the Eastern Oncology Cooperative Group for the Study of Brain Cancer

DUNN continued on page 48

. . . Medical Informatics

By Douglas Clement



The intersection of medical art and computer science holds great promise as more docs get in line to get on-line.

ILLUSTRATION BY SCOTT ROBERTS

Every day of his working life, 61-year-old internist John Levitt sits in front of a computer and feeds in data on his patients. Complaint, diagnosis, treatment, and prescription are all typed into his IBM clone. Over the past seven years, Levitt has stored more than 10,000 patient records on his hard disk, and he's thoroughly convinced that it saves him time by providing quick access to valuable patient information.

Levitt's colleagues, however, are utterly unimpressed. "I can't get any other doctor in this office to show even the most remote interest in doing the same thing themselves," says Levitt, sitting by his monitor at the Minneapolis clinic of Park Nicollet Medical Center (PNMC). "So I can tell you there's a real antipathy toward computers out there."

Fellow PNMC internist Mark Seaburg, M.D., is quite candid on the point. "Computers," he states, "are a pain."

But appearances to the contrary, the times are changing. Admitted hacker-docs like Levitt are slowly being joined by non-techie physicians who echo Seaburg's complaint but admit to being intrigued by various computer applications. "They're a pain you know where," says Lyle Munneke, M.D., a Willmar family practitioner, "but they're necessary and a help."

In fact, nearly two-thirds of Minnesota physicians responding to an informal *Minnesota Medicine* survey in June consider computers to be "very useful" in their clinical practice. Over half of responding physicians, of all ages and specialties, personally use a computer in their practice weekly or even daily (see "Survey: Computer-Phobia Not Widespread among M.D.s," page 14.)

It won't be a quick transition, and it certainly won't be painless, but the gulf between doctors and computers is narrower than ever before and closing with each passing day.

'Informatics'—A Kitchen Appliance?

The bridge over this gulf, the intersection of medical art and computer science, is called "medical informatics" by those in academia. It's an unfortunate term—sounds like something you might use to dice vegetables. By any name, though, its implications are staggering; "informaticians" foresee a day when computers will triage patients, correct diagnoses, and guide doctors in matters of life and death. Already, computers are used in medicine to locate articles and abstracts, design drugs, educate patients, and guide surgery (see "Medical Info-*what?*" page 10).

Even the most cursory list of computer applications in clinical practice illustrates the great promise of medical informatics. But despite the vast potential for faster research, more efficient information flow, time-savings, better decisions, and improved patient care, computers have not swept over the medical world as quickly as its advocates had hoped.

Indeed, medical informatics has often been treated with disdain by doctors. A scornful editorial in *The Lancet* a few years ago referred to informatics as a "bandwagon," saying that "whether such activities will benefit mankind, or even the profession, remains to be seen. ... How long will it be before we hear the cry that lives are being lost because a professor of medical informatics is not being funded to his entire satisfaction?"[1]

If doctors have at times been hostile, it is partly because early computer systems were so inept. Many medical record systems have been abandoned because they were unwieldy or too costly.[2] Friedman and Gustafson's survey of 32 clinical applications of computers found that 51 percent of them had been abandoned or suspended, and only 19 percent of them were in routine use.[3] Some systems, like one used in Calgary's Foothills Hospital, are downright dangerous. (That particular program reportedly has been known to spontaneously generate physician orders for blood transfusions and lab work and send the orders to nurses stations with electronic physician signatures.)[4] Others are simply cumbersome.

"There's a lot of snake oil out there," notes Michael Green, M.D., a Group Health family practitioner with extensive background in computer science. "A lot of systems being touted by developers are poorly done and when [doctors] go poke at them at conferences, they rightly assess them as being not very good. And so [doctors] are very suspicious, but I think it's justifiable." Green says the problem isn't a fear of computers, but rather, a concern about their utility.

David Rind, M.D., director of Harvard's Center for Clinical Computing, agrees that "computer-phobia" is not the real reason for physician resistance to the clinical use of computers. "When people build bad computer systems and they're not used by doctors, they say, 'well, you know, doctors don't like computers.' And it's just not true. Doctors like things that save them time. If a computer saves them time, they use it. If it costs them time, they don't use it."

Indeed, of all the hyperbole that has accompanied the computer age, none has misled so many so often as the

• • • • • **Medical Info**

promise to "increase productivity." Anyone who has tried to decipher an IBM manual, or seen an hour's work disappear into thin RAM, knows that lie too well.

A Question of Control

Physicians have also been concerned that the computerization of health care has been led by administrators and insurance companies—that it is an effort to control costs, not assist docs. And, of course, that's partially true. In a 1993 survey of 688 U.S. hospitals, 93 percent of top officials expected to increase spending on information systems by at least 10 percent a year over the next three years, especially on "integration of databases" and "improved decision support for clinicians."[5] Asked why, more than 55 percent cited pressure from the government and payers to control costs. Fewer than 10 percent mentioned a need to improve clinical care.

Of course, the two can go hand in hand; a better patient database system could improve patient care and control costs. But some physicians believe that using computers to control costs in a hospital also means controlling doctors.

"Doctors see the push for computerization coming from the insurance organizations and the HMOs," says Michael Green. "They see it as third parties just wanting to get their fingers further into our pot and wanting to control us more. I think it's a realistic fear, because that's what the administrative organizations want to do. And they don't really care if the automated medical systems will help the practitioner. They just want more control of data."

Lael Gatewood, Ph.D., director of the Division of Health Computer Sciences at the University of Minnesota, thinks increased physician interest in computers is in part a response to that struggle. "Physicians no longer want to see the administration of an institution capturing the database and using it for whatever things they can find on the administrative side," she says. "They want to be able to use the data for clinical care." Gatewood says she now gets five or six requests a day from physicians around the country who want to study informatics at the university.

Medical Info-*what*?

The term "informatics" has been used to cover all applications of computer technology to the practice of medicine, from mundane accounting systems to surreal "virtual reality" surgery. But while doctors might rightly scoff at the former as non-medical and the latter as hypothetical, they'd be wrong to dismiss the broad sweep of applications in between.

Research

As medical knowledge doubles every eight years, the capacity of computers to manage that information will become increasingly essential to physicians struggling to stay well-informed. An example: computers enable a doctor to scan MEDLINE's 3,600 publications in minutes and immediately pull up abstracts of all requested articles.

Computer crossmatching can dramatically speed searches for compatible blood and organ donors, improving health outcomes and reducing labor costs, patient sample requirements, and unwanted exposure to biohazards.[1,2]

Computer-aided drug design can speed development of new pharmaceuticals.[3] The Human Genome Project is highly dependent on computers to cata-

The Medical Record

Mundane as it sounds, the computer-based patient record is one of the most contentious areas of medical informatics, precisely because it involves questions of control over information, costs, and clinical practice (see this month's Special Reports, starting on page 16).

In Minnesota alone, a complex web of HMOs, hospitals, consulting firms, and quasi-governmental research organizations are jockeying for position in determining how patient data will be recorded and shared via fiber optics. MinnesotaCare legislation requires health care data collection and distribution, and organizations like the Minnesota Health Data Institute, the Alliance for Medical Information Networks, the Institute for Clinical

log and organize the massively complex genetic structure.[4] And researchers at the University of Minnesota and elsewhere are actively developing software to simulate epidemiological populations and then study disease in those populations.

Communications

Computers and the networks that link them can vastly speed the transfer of information among doctors and within and among health care facilities. In February 1994, for example, the National Library of Medicine used its international computer network to issue an immediate "clinic alert" reporting results from a study showing that AZT dramatically reduces transmission of the AIDS virus from infected mothers to newborns. In a matter of minutes, health workers around the world were apprised of the latest clinical recommendations.

Lab reports are now made accessible via computer in many U.S. hospitals. Electronic mail, long established in corporate America, is now making its way into larger hospitals. Many informaticians dream of computerized medical records flashing across town, or the country, electronically; others, including physician John Levitt, predict nightmares (see "Why Physicians Continue to Reject the Computerized Medical Record," page 17).

Medical education

Interactive compact discs (CD-ROM: compact disk-read only memory) that store text and video are being used with computers to educate patients about their medical conditions. At Park Nicollet Medical Center, urologist Erol Uke, M.D., has used videodisks with his patients to teach the pros and cons of surgery. Such programs curb not only unwanted surgeries, but also potential malpractice lawsuits because patients take the time to fully learn the risks and likely outcomes of surgery.

Medical students can also learn by CD-ROM. A program called "ADAM" (Animated Dissection of Anatomy for Medicine) allows students to visually peel back successive layers of skin, muscle, internal organs, and skeleton in a sort of video-autopsy. Its manufacturer calls it "a flight simulator for medicine" (see "The Anatomy Lesson: Software Puts the Body On Screen" in the March 1993 *Minnesota Medicine*, page 24).

Far more sophisticated programs let surgeons plan and practice technique prior to the actual operation. For example, ANALYZE, a software program developed by Mayo Clinic biophysicist Richard Robb, Ph.D., is widely used as a three-dimensional surgical practice program.

Imaging and image-analysis

Physicians have been increasingly receptive to capturing radiological information digitally and sending it electronically for interpretation. Computed tomography (CT) and magnetic resonance imaging (MRI) are,

Info-what? continued on page 12

Systems Integration, and the Minnesota Institute for Community Health Information are discussing how it might be done.

Some observers note that little attention and less money have been spent on the quality of the data to be collected and shared. "There's a lot of effort going into talking about sharing data and creating networks," says one physician familiar with the Minnesota process, "but if you share crap, it's still crap. ... If docs knew what was coming down the pike as far as the types of data that were going to be used to judge their performances, they'd be downright shocked."

Other observers are concerned about issues of privacy (see "Electronic Data Collection and Privacy," page 30). Although authorities claim that patient records will be stripped of identifiers and made available only to authorized parties, computer experts warn that most security systems can eventually be breached. By eliminating the difficulty of locating and accessing a patient's record, computerization creates a new problem: how can a patient's privacy be protected in a world increasingly run by computer networks?

Still, There's Progress

With all these roadblocks, it's a wonder there's been any informatic headway at all. But numerous medical centers across the country have developed sophisticated computer systems that are well-accepted by doctors.

Beth Israel Hospital in Boston has put in place a leading national example of a well-integrated computer system popular with physicians in both hospital and outpatient settings. In the hospital-based primary care

Info-what? continued from page 11

of course, possible only because of computers. Ultrasound images and even electrocardiograms can be analyzed by computer, with surprising accuracy.[5,6]

Expert systems

Doctors make mistakes; computers can help minimize them. Studies have demonstrated that computerized decision-support systems can improve diagnostic accuracy.[7-9] One program, for example, outperformed human physicians in correctly diagnosing myocardial infarction among 331 consecutive patients presenting to an emergency department with anterior chest pain.[10]

Other computer models can assist physicians in diagnosing illnesses by providing immediate access to large databases, recent research, differential diagnoses, and suggested treatments. Still others can screen a hospital's microbiology reports and identify early signs of infection. For better or worse, expert systems are also being used by administrators to monitor physicians, helping to identify providers who perform a disproportionate number of costly operations, tests, or other procedures.

Computer-aided surgery and virtual reality

With data generated by MRI and CT scans, computers can create 3-D images that guide surgeons during operations, much as Mayo's ANALYZE allows them to plan surgery. Mary Dunn, M.D., at United Hospital has pioneered these techniques in neurosurgery (see the Face to Face profile, page 6). Similar techniques will be or are being used in thoracic, bone, abdominal, and plastic surgery.[11-14] Physicians at Ipswich Hospital and the University of Sheffield in England are attempting to develop technology that will allow doctors in one location to examine patients in another through a computer technique called "virtual reality," which creates accurate 3-D images of remote objects.[15]

—*DC*

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practice, better than 90 percent of progress notes, medication lists, and problem lists are now captured electronically. Virtually all lab results are available instantly to physicians via 2,000 terminals throughout the hospital and its outpatient departments. Each week, approximately 20,000 pieces of electronic mail are sent and received through the terminals, and clinicians look up approximately 50,000 items of clinical information via terminal.

"There are a few doctors who don't use the computing system, but it's an incredible exception," notes Harvard's David Rind, who helps build and maintain the Beth Israel system. He stresses the necessity of making such systems user-friendly. "When we start getting questions about how to use something," he says, "we know we have to start thinking about redesigning it because we've done something wrong."

At Columbia-Presbyterian Medical Center (CPMC) in New York, a substantial number of medical records are automated; MEDLINE, the "Physicians' Desk Reference," and various other reference sources are on-line; and an automated system generates alerts for physicians if information entered into a patient's record is contraindicated by other data contained in that record, e.g., if digitalis is prescribed to someone who has low potassium.

The system is "well-received and well-used," according to Paul Clayton, Ph.D., director of Clinical Information Services at CPMC. "Many places start out by asking

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physicians to do their orders in the computer," observes Clayton, who says such systems are promoted by administration, not doctors. "Our physicians begged for access to the information and access to the library resources. They didn't beg for someone to look over their shoulder."

The Minnesota Story

In Minnesota, computerized clinical systems are less developed. Mayo Clinic's system features electronic mail and offers full access to lab reports by computer. Medical records are partially computerized, according to George Beeler, Mayo's chair of information services, "but we have a long-term goal to build toward a fully computerized record."

This goal may eventually be achieved through Mayo's joint sponsorship of ICSI, the Institute for Clinical Systems Integration. ICSI is a collaborative venture by Mayo, HealthPartners, and Park Nicollet Medical Center to explore a wider integration of information systems. Already, ICSI has developed a prototype work station for computerization of clinical data.

Other health care providers are increasingly active in developing integrated information systems. At Fairview Health System, Diane Strandlund, product manager for clinical information systems, is also working toward better provision of clinical information to physicians, but she admits that "we have years of effort ahead of us."

In a project called Total Recall, United HealthCare has developed a prototype of a wireless, hand-held computer that communicates via radio waves to UHC's extensive internal network, and through it, to other external networks. Using an inkless pen rather than a keyboard (and in a future model, perhaps, by speaking into it), doctors can enter data and commands into this tiny computer and gain access to national databases.

On a more modest (but fully realized) level, private practitioners like Samuel Carlson, M.D., of Wayzata Internal Medicine, regularly use a commercially written computerized medical record system that generates problem lists, medication flow sheets, and narrative records. His six-physician practice also has a direct line of communication with Methodist Hospital through a computer program that gives them access to narrative dictation, consultations, procedure notes, and lab and radiology reports.

More typical, perhaps, is Edward Fisher, M.D., a Park Nicollet Medical Center neonatologist. In his office, staff handle all computerized systems for appointment booking, lab retrieval, and x-ray retrieval. But Fisher's "personal use is really nil," he admits. "I know I need to be [familiar with computers] and would like to be. I just haven't personally taken the time to educate myself."

Computer Ed

More and more doctors are learning about computers. Indeed, many medical schools are requiring it. The

Medical Informatics • • • • •

medical school at Case Western Reserve University gives its students powerful 4-pound computers that contain a 6,000-page textbook for their first two years. The computers can also tap into the university's fiber optic network. Some Harvard Medical School professors and students are experimenting with 11-ounce palm-top computers that provide quick access to the "PDR," the "Merck Manual," and other reference aids.

About 30 American universities offer degree programs in medical informatics, half of them sponsored by the National Library of Medicine. U.S. medical schools offer approximately 100 informatics-related courses, according to Gail Mutnik of the American Medical Informatics Association (AMIA).

The University of New Mexico School of Medicine, for example, implemented a formal informatics curriculum two years ago. "The problem in medical education ... has been that we've had for the past 70 years a memory-based system of education," says Scott Obenshain, M.D., assistant dean for undergraduate medical education, who notes that all medical students at UNM now use computers in their studies. "Our projection is that ... you're not going to be able to practice medicine without one."

Wave of the Future?

Well, Hippocrates did just fine without an IBM, and such rhetoric brings out the Luddite in us all. But it seems certain that doctors will find themselves relying on computers with increasing regularity.

"It's the wave of the future," suggests AMIA's Gail Mutnik, noting that AMIA's membership has quadrupled in the past three years to a total of 3,200 members, 1,300 of whom are physicians. "And, as with any wave of the future, people take a little while to soften up to the new technology."

But even informaticians admit that waves can crash and back-ups are necessary. As Mutnik searched her

• • • Medical Informatics

Survey: Computer-Phobia Not Widespread Among M.D.s

An informal fax poll of Minnesota physicians indicates that doctors are far less "computer-phobic" than often believed. Well over half of physicians responding to the poll use computers regularly, and nearly two-thirds consider them "very useful" in their clinical practice. This non-scientific survey polled 75 physicians in the Minnesota Medical Association's Legislative Response Network and 40 other state physicians.

About 40 percent of the 65 physicians responding to the questionnaire indicated that they use a computer "daily," and another 18 percent said they use computers weekly. A quarter replied they never use computers clinically, and 17 percent said they "almost never" use computers.

Medical literature searches were by far the most common use for computers among responding physicians, followed by storage and retrieval of medical records, electronic mail, patient education, diagnostic assistance, and x-ray storage/retrieval. Doctors also mentioned using computers for lab data retrieval, presentations, medical discussion groups, administration, medical education, reports and articles, and prognostication of outcomes.

Nearly two-thirds of responding physicians said they consider computers to be "very useful" to medical practice, and about one-fifth said computers "sometimes serve a purpose." Only about 12 percent replied that computers "could be useful in the future, but not as currently available." A very small percentage was indifferent to their use or said they "waste time and resources." None replied that computers are "a threat to physician autonomy."

About half the doctors were familiar with the term "medical informatics," the application of computers in medicine. One noted it is "horrible grammar and choice of word."

Outstate physicians were the most enthusiastic about

computer for the phone number of a national informatics expert in New York, her voice suddenly dropped an octave.

"Our database just went down. I can't get into it. ... ummm. Hold on, let me go pull it off the Rolodex ..."

As the future washes over you, and your practice embraces the silicon chip, remember two things: never lose track of your Rolodex. Or your physician. MM

Douglas Clement is a Minneapolis-based free-lance writer.

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computers, with about two-thirds using computers daily or weekly versus about half of metro-area doctors. In addition, significantly more outstaters said computers are very useful. There was no apparent relationship between the year respondents completed their residencies and their attitude toward, or use of, computers

Methodology

Minnesota Medicine's questionnaire was faxed to 115 doctors throughout the state. Sixty-five (57 percent) returned the survey. Of the 65 responding, 42 (65 percent) were from the Minneapolis/St. Paul metropolitan area, and the remainder were from outstate Minnesota. Sixty (92 percent) were male doctors. Of the 115 total, 75 were members of MMA's Legislative Response Network; the other 40 were a random selection from *Mpls.St.Paul* magazine's January 1994 list of "Top Doctors" in the Twin Cities area (physicians recommended by their peers).

—*DC*

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The Paperless Patient Record

ILLUSTRATIONS BY NORA WILDGEN

Ever since the Institute of Medicine termed the computer-based patient record "an essential technology for healthcare," CPR has been a hot topic generating hefty debate. The following series of reports highlights progress to date in creating and implementing CPRs, discusses the reasons physicians have heretofore resisted computerization, and takes a look at a successful CPR in action at the Harvard Community Health Plan.

Why Physicians Continue to Reject the Computerized Medical Record

By John I. Levitt, M.D.

Information specialists often point a finger at physicians for failing to implement the computerized medical record, but this author argues that the systems' many shortcomings are to blame.

The continual lack of physician enthusiasm for the computerized medical record has distressed computer programmers and information specialists for at least 20 years. Their vision of the future electronic record as a vehicle not only for recording physician-patient interactions, but also as a facilitator of administrative functions, medical research, diagnostic support, and clinical alerts, often is in conflict with the practicing physician's vision.

The blame for failing to implement this new technology is usually laid at the feet of practicing physicians, whom information specialists often portray as recalcitrant admirers of outmoded past practices, unable to comprehend the potential benefits of modern computing power. On the other hand, one author has observed that the history of computing has many examples of users who were intimidated by the capabilities of computer technologies and mistakenly assumed that their reservations stemmed from ignorance of the technology, when in reality they may have stemmed from a thorough understanding of the problem.[1]

Several surveys reveal that the majority of physicians support the use of computers for patient care provided that the system supports the physician's role as a diagnostician and patient management decision maker rather than replacing or duplicating these functions.[2,3]

What physicians are resisting is the tightly organized, rigorously defined and coded medical record that requires data entry in a prescribed fashion, continual tracking of specific diagnoses and therapies, validation of diagnostic impressions, and acquiescence to a clinical support or clinical reminder subsystem.

Moreover, physicians are justifiably concerned that an all-inclusive electronic record, though undoubtedly a boon to a government bureaucrat counting the number of unreported gonorrhea cases or an insurance company looking to disallow payment for some pre-existing illness, may not necessarily be in the patient's best interest.

Unfortunately, the pressure on physicians to accept a comprehensive computer-based patient record (CPR) is certain to be intensified because the Institute of Medicine (a branch of the National Academy of Science) recently published a report proposing that such a system be instituted nationwide within the next 10 years.[4] This paper briefly discusses some questions regarding the validity of proceeding with such a proposal at the present time. The primary deficiencies or dangers inherent in a comprehensive CPR can be broadly grouped into the following five categories:

1. shortcomings of the physician-computer interface;
2. inadequacies of decision support systems;
3. defects in data coding;
4. concerns about patient privacy; and
5. distortion of recorded patient information.

Physician-Computer Interface

The principle obstacle to CPR remains the physician-computer interface. Any system that requires a physician to hit more than a few keys when accessing a medical record will almost certainly meet with resistance.

A drug prescribing system that automatically checks prescriptions for correct spelling, dosage, and possible drug interactions has been available for a number of years and is widely used by pharmacists. Such a system would be useful to physicians, but few use it. Young speculates that this is because of the extra time physicians must spend entering data. The physician, he notes, must locate a terminal and follow a set of instructions while typing in the prescription; even then, there is an approximate 10 percent initial rejection rate because of entry errors. In a manual system, errors are corrected by the pharmacy after a telephone call to the doctor; in a computerized system, doctors make all their own corrections.[5]

continued

Recently, a battle was waged at Canada's Calgary Foothills Hospital, where the medical residents resisted a push to have them enter all their orders into a new computerized record system with the acronym OSCAR.[6] Residents claim that OSCAR has become a major source of stress and that it causes conflicts between residents and nurses and between residents and attending staff about who should take time to enter the data.

Those involved, even the system's supporters, generally agree the system is not time efficient, adding as much as 30 minutes to three hours of work to the resident's day. To quote one of the promoters, "It's always going to be faster to tick off a box in a chart or write 'CBC' when you want a blood count. The new system doesn't boil down to a saving in physician time but saves work time for other staffers."

Data retrieval is much less of a problem, but the futuristic concept of physicians abandoning the old-fashioned paper display in favor of retrieving complex combinations of data via the user-friendly, well-organized monitor may need some revision. The advantages of paper are confirmed by no less a computer enthusiast than the vice president of information systems at Salt Lake City's Latter Day Saints Hospital. In discussing the customized patient information report produced by the hospital's HELP medical record system, he makes the following observation: "The vast majority of what [the physicians] want to see is in the computer, but it's a very complicated portfolio of data. The more you automate, the more difficult it can be to see the correlation. We've gone back to paper for this reason."[7]

Decision Support Systems

Decision support systems have a long way to go before they can be considered clinically useful. Most systems recently surveyed were still in the development stage and used only in the institution in which they were developed. Moreover, they were being applied within hospital or specialist environments, which differ considerably from primary care.[8]

Rector has summarized some of the unique characteristics of primary care medical practice that require consideration when designing a physician information system:[9]

1. Unlike an executive using an executive information system, a doctor's primary attention is on the patient rather than the system.
2. Doctors work under severe time pressures, perhaps 15 minutes per patient, and the usual focus is on a quick solution to a current problem, not long-term planning.
3. A tremendous variety of problems need to be solved, none of them occurring often enough to justify a system specific to the problem.
4. Doctors work under serious information overload, which may be aggravated by even the best information system.
5. Doctors have a wide diversity of clinical skills with great expertise in some areas and major deficiencies in others.

A study by Timpka et al. analyzing the decision dilemmas that general practitioners face illustrates just how difficult it would be to develop a satisfactory support system for general practice.[10] Medical dilemmas were reported in 75 percent of encounters, but very few of these were due to problems arising during "hypothetico-deductive reasoning." Rather, they were vague concerns, such as uncertainty about the accuracy of the medical history, uncertainty as to whether a particular physical finding was present or absent, or concerns about the correct interpretation of the patient's body language.

The problems were ill-structured and did not fit any existing model; most were so complex and perplex-

ing that general practitioners had a hard time articulating the problem. Necessary problem-solving skills were described as "the know-how of coping with everyday activities." The knowledge necessary appeared to defy formalization and may, therefore, only be acquired through personal experience.

Even if a system could satisfy these requirements, would physicians use it? As Rector observes, "There are few obvious gaps in the available network of sources of expertise waiting to be filled by 'expert systems.' " The referral and consultation patterns between physicians are part of a social, intellectual, and financial network that many M.D.s would be reluctant to abandon.[9]

"Proponents of computerized medical records must recognize that physicians have legitimate concerns about how records will be structured and utilized."

Coding

For the data contained within a CPR to be useful, they must be coded in a fashion that permits accurate retrieval by a multitude of users who may be recalling information for quite diverse purposes. No current coding system can satisfactorily allow this.

Nowlan[11] notes that the two uses for a coding system are incompatible. These uses are 1) to keep patient records for the clinical management of the individual, and 2) to collect, analyze, and interpret aggregated data.

The first purpose requires a system able to accommodate expressions of uncertainty and provisional diagnoses, as well as "concepts," such as the patient's reason for the encounter. Because many of the diagnoses will change during evolving patient care, no clinician would accept a system that requires all codes to be absolute truths. Medical records contain many diagnoses recorded in a perfectly reasonable manner but that are subsequently disproven.

On the other hand, such expressive features are anathema to the second purpose—to collect and analyze data—which requires data that are precise, absolutely correct, and immutable. Aggregating data requires accurate and consistent coding, but this may not be possible. As a simple example, Shepherd[12] notes that the terms gastritis, dyspepsia, and indigestion are not synonyms, but there is no evidence of consistent usage. He is particularly concerned with a tendency to define codes at a level of detail beyond what can be accurately defined and appreciated. "We may aggregate nonsense as effortlessly as we aggregate fact," he writes. One may easily, he notes, fall into the common medical trap "where having found we can measure something, we do measure it, and then because we have measured it, we attribute significance to it. ... It may be possible to allocate 250,000 codes to codify the whole of medicine. Having allocated the codes, we use them and we count them and because we have counted them, we attribute significance to them. But what have we actually achieved? ... It is easy to measure, but is it worthwhile?"

Privacy

Physicians are concerned that computerization of medical records will seriously threaten the privacy and confidentiality of those records (see "Electronic Data Collection and Privacy," page 30). One basic issue relates to the conflict between the record as a vehicle for supporting individual patient care and the record as used by other interested parties. Andrews et al. note that "while patients give their clinician implicit consent to think about their case, discuss it with colleagues, and evaluate progress, they certainly did not give a blanket approval for their data to be used by other medical professionals, no matter how proper the use may be."[14]

An Australian computer scientist dispels what he terms "the myth of security" in a computerized medical record.[1] He claims the major threat to amalgamated databases is not from remote hackers, as may commonly be believed, but from departmental staff using the system. "One of the common illusions about computer systems is that they have sophisticated security controls that can maintain high levels of confidentiality," he writes. "No matter what high standards of recruitment are employed, any large organization will inevitably employ a percentage of corruptible individuals.

"To obtain medical information about all the current Cabinet Ministers, an inquirer would currently need to corrupt one of the dozen staff at each of more than 20 practices throughout Australia. Obtaining the same information from a central government database would require the corruption of only one of the large number of users of that database, who may be scattered all over Australia."

Information Distortion

Many physicians express reservations about the validity and reliability of the information contained in a coded electronic medical record, particularly when that infor-

mation is used for a multitude of unrelated purposes. Rector et al. write, "We maintain that the principle purpose of the medical record is to support individual patient care. The design of many existing electronic medical records derives, implicitly or explicitly, from support for the use of aggregated data for research, audit, finance, or planning. We maintain that such designs are inappropriate for a record of clinical use and, ultimately, inadequate."[13]

One type of data distortion derives from the need to compartmentalize data into predefined categories that will permit their use for particular applications, usually clinical research or epidemiology. These usually require that a single "correct" value be entered for each sign or symptom, whereas in reality much of the data is "soft," of uncertain reproducibility, and of unclear significance. To record symptoms with a single code distorts the truth.

The second type of distortion results when a physician, recognizing that the recorded information may be used for a function not in the patient's best interest, selectively processes the data placed in the medical record.

Musen recounts, for example, how an insurance company misconstrued data in a medical record to justify denying further hospitalization of a very ill patient. He notes, "My personal plans are to make sure that future entries into my patient's medical record will convince this particular insurance company that my sick patient indeed requires hospitalization," even though the slanted data will be less valuable to researchers or epidemiologists.[15]

A physician survey revealed that 50 percent of physicians would misrepresent a patient's medical history to conceal treatment of a venereal disease from a spouse, and 70 percent would do so to obtain payment from an insurance company for what would otherwise be classified as a disallowed service.[16] Burnum notes that physicians are generally reluctant to include information that, although pertinent, might be considered defamatory, such as uncomplimentary comments about a patient's appearance, manner of dress, educational level, intelligence, or diagnoses that might be considered stigmatizing, such as alcoholism, homosexuality, or paranoia.[17]

The possibility that physician-recorded data may not be suitable for alternative purposes strikes at the very heart of CPR as currently envisioned. But, as van der Lei notes, "Data as such do not exist in nature; data are man-made artifacts. Data are collected with a purpose in mind; when usage of the medical record changes, the recorded data changes accordingly. ... In practice, however, the correct use of data often is not defined. When researchers perform epidemiological studies using routinely collected data from hospital information systems, for example, they may find it difficult to trace why and how the data were collected; they require an understanding of that context, however, to interpret the data correctly."[18]

For the reasons noted above, such data may be inaccurate or incomplete. To prevent distortion, most physicians would probably agree with van der Lei's proclamation that "we must restore the medical record to its rightful role: a faithful record dedicated first and foremost to documenting the medical care for individual patients with the express purpose of ensuring quality of that care. And consequently, we should protect that medical record from abuse, that is, using the data in any way that might compromise its intended use."

Van der Lei proposes what he terms the first law of medical informatics: "*Data shall be used only for the purpose for which they were collected. If no purpose was defined prior to the collection of the data, then the data should not be used*"[18] (italics his).

Conclusion

Proponents of computerized medical records must recognize that physicians have legitimate concerns about how records will be structured and utilized. As long as the medical record is used as a tool for providers to store patient data, physicians are enthusiastic partners in the operation. Limited records that permit easy recall of laboratory and x-ray results and that tabulate recent visit dates and diagnoses are already in operation and freely used by physicians in the Twin Cities and elsewhere. But when an Institute of Medicine committee declares that "the patient record system of the future must provide other capabilities as well, including links to administrative, bibliographic, clinical knowledge, and research databases," and that the "computer-based information management systems must be able to communicate with providers, third-party payers, and other health care entities,"[4] physician resistance should be considered a perfectly appropriate response to a highly controversial subject, rather than dismissed as a manifestation of computer anxiety. Until the committee addresses and resolves the shortcomings of comprehensive electronic records as detailed in this paper, it should not expect endorsement from practicing physicians. **MM**

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The Computerized Medical Record in Action

By Charles R. Meyer, M.D.

Minnesota Medicine's editor-in-chief found a true success story when he visited Harvard Community Health Plan in Burlington, Massachusetts, to investigate its computerized medical record.

The wooden chart racks outside our office exam rooms have two-inch openings to hold medical charts. Many of my patients' charts either will not fit in the slot or require two hands to be lifted out. This is but one weighty argument for computerized medical records. Proponents of the computer-based patient record (CPR) also cite accessibility, readability, organization, and ease of compiling population data. The 20-year search for a workable CPR recently received a considerable boost when an Institute of Medicine report urged the implementation of automated records by 1996 and when CPR was included in the mandate proclaimed by President Clinton's Health Security Act.

Why has it taken so long for computers to crack the clinical arena of medicine? Certainly, hardware had to get cheap enough, fast enough, and small enough to be practical in an outpatient setting. Software developers needed to construct sophisticated database tools to handle clinical information and flexible graphical user interfaces that allow rapid access to multiple parts of a program. But perhaps the major stumbling block to the adoption of the CPR is the nature of the provider-patient encounter. Patients give us information in a semi-directed, semi-random sequence. As providers, we try to fill in the blanks by asking focused questions and then transcribing the data in an organized (we hope) text tome called the medical record. The completeness, readability, and pertinence of this document all hinge on the provider's time, compulsivity, and concentration. Critics of using the CPR to collect clinical data contend that computers will coerce clinicians into inflexible, sometimes irrelevant paths of recording data, resulting in distraught docs, nasty nurses, and cursed computers.

Can computers work in a clinical setting and produce a useful medical record? Although many small offices have tried CPRs, I decided to observe a computerized patient record in operation at a medium-sized clinic. The Harvard Community Health Plan (HCHP) opened its doors in 1969 as an alternative to standard health care delivery, joining health care payment and delivery and placing most outpatient services under one roof. It has grown from 88 members when it first opened to 545,000 members in 1994 with revenues of more than $1 billion. HCHP delved into computerized records many years ago with the COSTAR system, which is still operating at many of its clinics. In 1988, it formed InterPractice Systems (IPS) as a partner with Electronic Data Systems, a General Motors subsidiary. The CPR that emerged from the development of IPS was installed two years ago at HCHP's Burlington clinic.

The Robert H. Ebert Burlington Health Center is an attractive, two-story building set in suburban Boston. It houses seven internists, three pediatricians, two physician assistants, two nurse practitioners, a psychiatrist, a child psychologist, and a psychiatric social worker. Clinicians from the nearby Lahey Clinic consult on a part-time basis, sharing Burlington's comprehensive support medical services, including laboratory, x-ray, pharmacy, and visual services. Like George and Marion Kirby on the old TV series "Topper," I trailed Dr. Barry Zallen through an afternoon of patients, trying to remain invisible but peppering him with questions at opportune times. Zallen is a 40-year-old pediatrician who divides his time between clinical practice and his duties as the center's chief

physician. During the afternoon I was with him, he saw 10 patients, with an average complement of pediatric problems.

The Setting

Dr. Zallen has access to a computer in each exam room and in his office. The computer in his office has a 21-inch monitor connected to a Macintosh work station as a user-friendly front-end for a VAX server, where the "guts" of the program reside. The unit utilizes keyboard and mouse with a full graphical user interface, like Windows or Macintosh, as opposed to the old-style DOS interface, which requires the user to memorize commands. Each exam room has a smaller monitor with nearly full access to the system but requires use of the keyboard to maneuver around the screen. The physicians at the health center each create their own style for using the system. Zallen interacts with the exam room computer during well-baby visits. For acute illnesses, he works from a "quick profile" paper printout and finishes his computer work in his office after leaving the patient. (The "quick profile," which is printed at the time of patient registration and discarded after use, contains demographics, appointment information, a problem list, most recent vital signs, drug allergies, active medication, and notes from recent visits.)

"The CPR is alive and well at Burlington Health Center."

The Program

After the physician signs in with a user name and password, a screen alerts the physician of lab results, dictation, and bulletins needing review. The physician can then click on the appropriate box to bring these items up. Lab and x-ray results, pending and completed, are displayed with normals. The clinician can elect to erase after viewing, see the rest of the patient's record by clicking on a box, or obtain the patient's phone number to discuss the test results. By clicking on other icons, the physician can create a telephone encounter form and record notes about the conversation. A more commonly used option, however, is to print a letter to the patient stating that the tests were normal. The physician's action is automatically documented.

To view the records of that afternoon's patients, Zallen clicks on a "bulletins" screen and then opens a list of his "open encounters." As patients register at the front desk, their names appear on the screen, and Zallen selects them to bring up a new encounter form in his office and in the exam room. The registration desk enters the reason for the visit on the encounter form. The doctor then chooses problems from the patient's problem list, a personal, pre-defined list, or a more complete list of diagnoses and problems. Text can be entered by typing, pasting from a "scrapbook" of frequently used phrases that the physician has previously entered, dictating, or using structured data input (SDI), which consists of pre-defined templates or check-lists that include any items the clinician wants. The user either accepts the defaults or enters new data as free text. Zallen uses SDI primarily for well-baby visits, selecting "normal" details for the physical exam and typing in abnormal findings where appropriate.

How the System Works

Office visits: Zallen types most of his notes, either in the room with the patient or in his office. He uses the scrapbook frequently and SDI for well-baby visits. Zallen's use of the computer in the exam room did not seem to interfere with patient communication, although Zallen suggested that this may be more true with pediatrics because the doctor can discuss the case with the parent and input data while the child dresses. Most of the internists at Burlington apparently do their inputting outside the exam room. Having worked with paper systems, Zallen feels the computer has not added to the time it takes to generate an office note; his notes are organized logically and are comprehensive.

Lab/x-ray orders: Ordering lab work and x-rays is accomplished by clicking on a box, picking the test, supplying one line of clinical data for x-rays, and clicking to send the order to the in-house lab and x-ray desks.

Medications: The procedure is similar to that for lab work. Physicians select new prescriptions from a list, supply the number and "SIG," electronically sign the prescription, and then send it electronically to the pharmacy. Most prescriptions Zallen filled out while I was there took less time than writing out an equivalent prescription. In addition, the prescription was automatically documented in the record. The advantages of an in-house lab and pharmacy are clear, but this system could work with multiple, independent pharmacies.

Forms: Although the system can generate user-created forms, Zallen handwrites most forms, e.g., school and camp. When I asked whether other areas of the clinic use the system to fill in forms, he inquired and discovered

that they have been filling out "attending physician forms" by hand. However, as a result of Zallen's question, they plan to start using the system for such forms. Also, the pediatric department will soon begin using an automated school and camp form.

Telephone calls: Telephone calls can be documented by clicking on a box titled "Create Telephone Encounter." Zallen did not document all telephone calls; he tended to record only those that resulted in his calling in a prescription. The advantage of having immediate access to the medical record when calling patients—without having to "call for a chart"—is obvious.

Prescription refills/renewals: I saw Zallen renew a prescription only once, and it was almost identical to ordering a new prescription.

Decision support: Although clinical algorithms are available from within the program, Zallen did not use any. He said the clinic is currently reviewing all algorithms, with the goal of endorsing their use in daily practice.

Data analysis: One of the potent forces driving the push for CPR is the ability to easily examine physicians' practices and measure and define quality. The physicians at Burlington have used the data retrieval capabilities of the IPS computerized medical record for pinpointing children who fall through the cracks in getting routine immunizations. In addition, the clinic recently completed a study of its asthma patients. This year, HCHP released a study of 100 indicators of quality and patient satisfaction, and, according to Zallen, data generated by the IPS computerized medical record contributed extensively to this report.

Summary

Before the advent of the IPS computerized medical record at Burlington, Zallen did not own a computer. Although he learned touch-typing in high school, he emphatically states that he hated it. The average age of the physicians on staff at Burlington is about 40, but few had extensive previous experience with computers. According to Zallen, all have adapted to the CPR with few tears or tirades. The physicians continue to "tweak" the system to customize their own scrapbook and templates. Lahey physicians who work at Burlington part time are using the system, although with more staff help.

The CPR is alive and well at Burlington Health Center. HCHP physicians can and do use computers in their daily work, producing quality medical records that are readable and retrievable. Nonetheless, promises that computers will make records more complete and accessible and will improve quality measurement will be mere blather if the CPR doesn't make users' lives easier. My last question to Zallen was "How has this system made your life harder?" After one pensive second, he replied, "I really can't think of anything." To me, that is potent testimony that the CPR is not a techie's fantasy, but rather, a pragmatic, workable answer to the needs of 21st century medicine. MM

Charles Meyer is editor-in-chief of Minnesota Medicine *and an internist with Consultants-Internal Medicine in Edina, Minnesota.*

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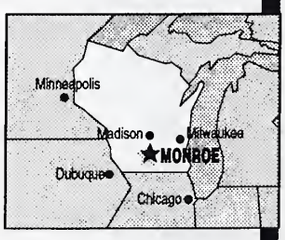

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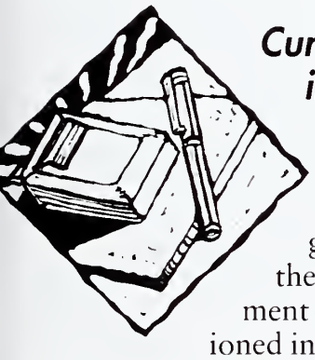
The Computer-Based Patient Record Institute

By Paul C. Carpenter, M.D.

Clinical computing is moving forward nationwide with help from CPRI, a coalition of organizations promoting the computerized medical record.

As a member of the board of directors of the Computer-Based Patient Record Institute (CPRI) for the past two years, I have had the good fortune to participate in deliberations concerning the adoption of clinical computing. This article offers some perspective on the current state of medical record systems and the role of CPRI in the advancement and evaluation of computer-based patient record (CPR) systems.



Current State of Computers in Medicine

The paper-based medical record has been in place for nearly a century and has served the caregiver admirably. In my institution, the Mayo Clinic, the wise establishment of a unit medical record was fashioned in the second decade of this century and has evolved into a system encompassing more than 6 million patients. That record is complete, familiar, portable, browsable, and flexible. We have been fortunate that the integrity of our record system has been nurtured by caring and solvent management. That luxury is not shared by all physicians; many must struggle with inaccessible, incomplete, illegible, and inaccurate records, as well as redundant information residing in multiple records.

Numerous studies have demonstrated these problems. The Government Accounting Office studied one large hospital that could not locate patients' records for 30 percent of patient encounters. Content flaws are also evident, including redundant testing because of the unavailability of results, omissions of critical data (age, height, weight, allergies, etc.), inadequate problem documentation, and missed diagnostic coding. The major deficit of our paper records may be their lack of integration and linkage, the primary example being the chasm between inpatient and outpatient records.

The majority of practice sites have begun to automate components of their medical record systems, mostly for accounting, billing, and administration. Of those institutions that have begun computerization for practitioners, the majority have created a computerized record that resembles the existing paper record, promoting familiarity and ease of transition. Like the paper record, most of these systems use compartmentalization for information about the patient, including folders for history and physical, laboratory, radiological, and other result categories. This implementation is flawed and misses the opportunity for re-engineering the medical care process. Appropriate information technology will support change and promote innovations in the practice of medicine. But few CPR vendors have been bold enough to incorporate innovative concepts into their products, probably because they fear that physicians will resist the unfamiliar or perhaps because the vendors simply lack the vision. CPR's greatest benefit will likely be the empowerment of physicians through tools that extend and enhance their capabilities.

CPRI

In April 1991, the Institute of Medicine released a report entitled "The Computer-based Patient Record—An Essential Technology for Healthcare." This report pointed out the numerous shortcomings of the paper medical record and called for the creation of a public/private body to "promote and facilitate development, implementation, and dissemination of the CPR." To that end, the Computer-Based Patient Record Institute (CPRI) was formed in January 1992 as a coalition of organizations involved in health care with the mission to "initiate and coordinate urgently needed activities to facilitate and promote the routine use of computer-based patient records."

The most obvious change in CPRI over the past two years is growth, both in numbers and maturity. The decision to form CPRI was finalized and interim direc-

tors were seated for the first time to discuss "who we are" and "what we are up to" in January 1992 at the American Medical Association headquarters in Chicago. Since then, the organization has increased its membership more than 500 percent. That membership comprises a variety of stakeholders in health care so that all views and needs may be addressed. Seated at the table are physicians, nurses, hospitals, insurers, managed care organizations, hardware and software vendors, government agencies, universities, patient advocacy groups, medical records professionals, transcriptionists, pharmaceutical representatives, and many others.

CPRI, now post-adolescence, is launching itself into the adulthood of its mission and directing its activities at the following six goals:

• promoting the development and use of standards for computer-based patient record structure and associated messages, communications, codes, and identifiers;

CPR: Making It Work

In the two years I have worked with CPRI, I have observed progress in automation of the patient record during my visits to sites around the country. My observations have been exciting and encouraging. There is no question that the most functional CPR efforts have involved all users, including doctors, nurses, and technicians. The following is my advice for creating a functional, universally accepted CPR system.

Share responsibility with other organizations

Across the country, there is a great deal of unnecessary duplication of effort. Many hospitals, medical practices, and other care sites have launched into the computerized medical record alone. Because of limited resources, they must rely on "off-the-shelf" solutions. Some have felt major time pressures, resulting in inadequate assessment of systems and eventual unhappy and unproductive users. A far better approach is to pool resources with multiple caregiver sites. This will increase funds for the project, as well as increase productivity concerning design, negotiation, and system testing.

Involve caregivers in CPR development

Physicians have, in many cases, resisted the move to computerized medical records, often because of flaws in the systems (see "Why Physicians Continue to Reject the Computerized Medical Record," page 17). Physicians and other providers must be involved in the decision-making process to assure that CPR systems are efficient and useful for clinicians, not just administrators.

Fortunately, numerous good examples of clinician involvement in the decision process can guide others. Examples of the successful implementation of clinical computing systems with high user acceptance have some common characteristics.

Caregivers should be involved from the earliest stages of planning. Administrators should request the opportunity to view the care process and ask physicians how technology could improve it. Experienced clinicians can then offer suggestions, perhaps derived from their pet peeves: "I can't get the record when I need it," "It would help if I had the formulary immediately available rather than having to fumble through that stack of books at the nursing station," "I would like a means of tracking my problem list on individual patients along with their prescription record," etc. These interactions define physician needs and help create a product description.

Clinicians, however, often have difficulty envisioning the possibilities of clinical computing. Some planners have fashioned example system components to use as discussion points, but this must be done with caution to avoid restricting clinicians' vision of a system's potential. Questionnaires should be avoided because their structured design can restrict open thought.

A targeted group of clinicians should participate in the planning process, representing the entire clinical staff. Those involved must carry the respect of their peers and be able to communicate with both physicians and administrators.

Clinician selection should follow certain guidelines. Volunteers tend to have significant experience with computers and often focus on technical aspects without addressing broader goals. Individuals from diverse backgrounds and specialties should be recruited. Nurses, technicians, and clinical clerical workers

• demonstrating how computer-based patient record systems can improve effectiveness and efficiency of patient care;

• encouraging creation of policies and mechanisms to protect patient and provider confidentiality and ensure data security;

• educating health professionals and the public about CPR;

• promoting computer-based patient record research activities; and

• serving as a clearinghouse for efforts to promote and develop activities related to computer-based patient records.

CPRI work groups

CPRI functions primarily as a change agent. Its work is predominantly carried

should also be involved. This team of individuals should be kept intact for the duration of planning and implementation; they serve as liaisons to their constituencies and foster a sense of ownership.

As a side note, involving nursing personnel has merit. The parallel development of a nursing information system and one to be used by clinicians is a considerable waste of time and funds. These professions have common needs for CPR systems.

It's important to facilitate physician involvement by granting adequate time to participate. If this new responsibility adds work to the physician's busy day without incentive, participation will diminish as time goes on. Useful methods to encourage physician involvement can be found in "The Physician-Computer Connection: A Practical Guide to Physician Involvement in Hospital Information Systems."[1]

In many hospitals or clinics, particularly larger ones, the creation of a body that crosses multiple administrative lines can be the most efficient means of managing these often large computer projects. Proposals that arise from individual departments may have features in conflict with other developments. An information master plan should be created and endorsed by several administrative bodies, including clinical, nursing, pharmacy, laboratory, radiology, information services, and administration. It should then be implemented by an administrative body with representation from the above constituencies and with authority derived from senior management.

Remember the key components

What are the characteristics of systems that have gained solid acceptance by physicians and nurses? The answer to this question can serve as a benchmark for planning. The successful CPR has two key components: 1) it delivers the right information at the right place and the right time, and 2) it conserves time.

The core of clinical care is the diagnostic and treatment decision process. Delivery of information to assist in that process is the critical ingredient in clinical computing. This information needs to be available when and where needed—the point of care, the office or home, and sites where physicians and nurses discuss patients among themselves. Technically, systems must be designed with optimal retrieval and display speed.

Second, the clinical computing system can't be slower to use than paper records. Multiple steps, key strikes, and mouse clicks present barriers. Complex menus must be avoided.

Elements that help make CPR useful include integrated views of current patient information; customized options for each individual clinician, such as screen color or shading, display integration, data views, record organization, and graphical representations; and automated alerts or prompts. Coupling the medical record with the local e-mail system, information databases such as MEDLINE for literature retrieval, on-line medical/surgical texts, formularies, and drug information such as the "Physicians' Desk Reference" also adds value.

Institutions that follow the above advice will lay the foundation for the enthusiastic involvement of clinicians and alleviate fear about loss of control over clinical decision making. *–PCC*

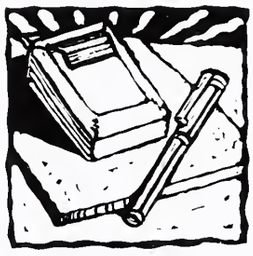
REFERENCE

1. Bria W, Rydell R. The physician-computer connection: a practical guide to physician involvement in hospital information systems. Chicago: American Hospital Publishing, 1992.

out by four work groups: Codes & Structures; Professional & Public Education; Confidentiality, Privacy, and Legislation; and Systems Evaluation. These work groups are already responsible for notable accomplishments in their short two years of existence.

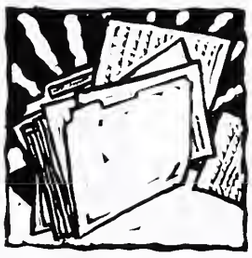
Codes and structures: The Codes and Structures Work Group has and continues an extensive review and analysis of existing communication standards that relate to health data, drug code systems, comprehensive code systems (diagnosis, procedure, symptom, CPR content, and outcomes), and procedure code systems to make recommendations regarding their applicability and use for computer-based patient records. This work group sponsored a panel discussion at this year's CPRI annual meeting in July on the universal patient identifier, a necessary element for transmission of patient information between care sites in the future. This discussion was urgently needed because it is obvious that the Social Security number, adopted by many federal and other agencies as an identifier, will not serve the needs of a global health network because of its many flaws in integrity and security (see "Electronic Data Collection and Privacy," page 30).

In March 1994, CPRI announced a major project to accelerate standards development for CPR systems. The current standards development process works but is perilously slow. This new effort is critical to timely development of effective CPR systems because we have major problems connecting disparate computer systems, almost no uniform record content definitions, and only moderate accord in messaging standards between computers and medical devices. This effort has received enthusiastic support from the users, vendors, and those in standards development. Federal agencies involved in health care also have endorsed this undertaking.



Professional and Public Education: Educating health professionals and the public about the CPR is another goal of CPRI. Implementation of CPRs will require cultural and organizational change for health care professionals and providers. The Professional and Public Education Work Group is defining key issues for professional education and is developing communications and presentations. The work group already has established a speakers bureau and developed slides, a video, an exhibit, and print presentations.

Confidentiality, Privacy, and Legislation: Major legal hurdles must be overcome before computerization can be accomplished. The Confidentiality, Privacy, and Legislation Work Group has conducted a thorough state-by-state review of statutes related to the creation, ownership, authentication, and retention of health information and plans to offer a uniform nationwide retention policy and model legislation to support electronic archiving of health information. This group also offers clinical expertise to various technical groups. Because state laws vary significantly and many gaps exist in legal requirements, the group has been asked to develop model legislation for federal review and has testified before committees of the House and Senate. Its recommendations have been cited in current health system reform legislation.



To encourage the creation of policies and mechanisms to protect patient and provider confidentiality and to ensure data security, this work group has also collected models of trust from other industries and is preparing a document on principles of access and use of patient data in CPR systems. This group is also preparing a paper on sanctions for confidentiality violations that will draw from the work of voluntary standards organizations that are defining confidentiality ethics.

CPR Systems Evaluation: CPRI's Systems Evaluation Work Group is developing criteria for evaluation of computer systems as applied to patient care. This task was initiated by production of an electronic compendium of literature related to benefits, quality, and costs of computer-based care systems. The compendium is updated by periodic review of literature in the field.

CPRI recently announced a program to acknowledge excellence in computer-based patient record systems. The Davies Recognition Program fosters further development of quality CPR systems by recognizing health care organizations and their vendor partners that successfully use CPR systems to improve health care delivery. The work group, with input from national experts, has developed a set of evaluation criteria that can be used as a framework for describing and evaluating CPR systems projects. In April 1995, a Davies Symposium will be held in conjunction with the annual National Managed Health Care Congress in Washington, D.C.

The Davies Recognition Program will culminate in a series of awards, similar to the Baldrich Award for quality in manufacturing and service, for those institutions that demonstrate quality improvements resulting from using CPR systems in patient care.

Other CPRI efforts

CPRI expects to promote CPR research. Since its beginning, the organization and its members have served as resources for institutions and vendors developing CPR systems. A research initiative is under way to survey the current state of hospital information systems and practice management systems concerning their efficacy and support for CPR systems in hospitals, physicians' offices, and other health care delivery settings.

The organization envisions that the CPR will not simply be an automation of the existing medical record or expansion upon claims processing systems, but will be a re-engineering of the medical record into a tool used routinely by health care professionals and others with legitimate right to access.

CPRI's vision statement is as follows:

1. The health care delivery system must use a comprehensive, longitudinal patient record to provide all clinical, financial, and research data.

2. While maintaining the confidentiality of sensitive patient and provider data, the CPR will contribute to more effective and efficient care through:

- universal, timely, and intuitive access to lifetime health data collected and maintained across the continuum of care;
- support for continuous quality improvement in health care delivery;
- ready access to knowledge bases to support clinical practice, administration, education, and research; and
- patient participation in health status documentation, wellness, and disease prevention.

CPRI members have given numerous presentations to help convey the importance, urgency, and nature of CPR. The institute has been called upon to provide assistance to investment bankers, venture capitalists, consultants, market researchers, and potential purchasers.

Though only two years old, CPRI has been busy and productive and is creating an exciting environment. It has become attractive to those who propose health care legislation that recognizes the critical need for CPR in meaningful health care reform. In large part, this is because of the institute's character—it is a body whose only agenda is the success of universal CPR implementation, with no vested interest in profit or political gain. Several Minnesota health organizations are now members of CPRI. For more information, contact CPRI at 800/382-2973.

I am hopeful that 1994 will be remembered as the opening of an era of truly practical and effective clinical computing. Unfortunately, we have to date few real examples of clinical computing that carry these credits. Success has been elusive for several reasons—but not for lack of creative or industrious persons laboring in the field. MM

Paul Carpenter is a consultant with the Division of Endocrinology at the Mayo Clinic in Rochester, Minnesota, and chair of the board of directors for the Computer-Based Patient Record Institute. He may be reached at pccarp@mayo.edu.

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Electronic Data Collection and Privacy

Minnesota and the nation are working to develop electronic collection and storage of health care data, but is the information superhighway the right place for personal medical records?

Andrea M. Walsh, J.D., and Shirley Qual, J.D.

Of all the monumental changes taking place in our state's and nation's health care delivery systems, the centralized collection and dissemination of health care data may be the most cumbersome to achieve and most objectionable to the public. Health system reform has been driven by the need to reduce overall costs, expand access, and provide better information so consumers can make informed decisions. While most health care consumers are preparing for various changes in the delivery of health care, few are probably aware of or ready to accept the burgeoning data collection system that will store all their personal health data. Consumers want better health care information, but they may not be comfortable including their own conditions and treatments in the database. This article discusses the data privacy concerns raised by the contemplated data collection system.

Individual Right to Privacy

The "right" of an individual to keep medical information confidential is not a right conferred by the Constitution but, rather, a strong public policy arising from the notion that significant benefits are derived from keeping medical information private. This public policy runs deep in the culture and history of the United States and is supported by many state and federal laws, as well as professional codes of conduct. With increasing governmental involvement in health care administration and the advent of health system reform mandating global cost savings and quantifiable quality improvement, standards previously applied to privacy must be viewed anew. The traditional balance is likely to shift, but to what degree remains to be seen.

Data Transmission Raises New Privacy Concerns

A balance is needed between individuals' desire for privacy and the public's need to have accurate and reliable information to gauge the effectiveness of health plans. MinnesotaCare legislation has endorsed a public-private partnership through the creation of the Minnesota Health Data Institute, which is charged with designing and implementing an integrated, statewide health care data system to meet the informational needs of consumers, providers, health plans, purchasers, policymakers, and researchers. To accomplish this monumental task, the Data Institute is focusing its efforts on developing a data infrastructure linking electronic networks through electronic data interchange (EDI). The Data Institute also will develop a statewide data repository to facilitate access to patient data for all those who legitimately need access. Recognizing the critical need for protecting confidentiality, the Data Institute has developed an Ethics and Confidentiality Committee, which is contemplating the development of a health care information data privacy act.

In addition, the 1994 Legislature created the Minnesota Center for Health Care Electronic Data Interchange as a broad-based effort of public and private organizations representing group purchasers, health care providers, and government to advance the use of EDI in the state. This new entity is charged with coordinating quality EDI education and training; developing EDI education curriculum; developing communication and marketing plans; and administrating a resource clearinghouse for EDI information, including a health care constituents database, health care directory, resource library, and other services outlined in the law. The center is also charged with providing technical assistance in developing implementation guides, as well as legislative, legal, and confidentiality requirements.

On a national level, the Workgroup for Electronic Data Interchange (WEDI), a public-private task force established in November 1991, is developing an action plan to streamline health care administration by standardizing communications across the country. In its 1992 report, WEDI recommended that uniform federal legislation be passed to supersede any state laws that may affect collection, storage, handling, or transmission of health data.

Although it is unclear at this point whether data collection standards and regulation will ultimately be controlled at the state or national level, the Minnesota Legislature has begun

setting up a regulatory framework. Regardless of who controls regulation, the issues of privacy are the same. The Data Institute and WEDI continue to grapple with establishing individual identifiers, restricting access, ensuring accuracy, and controlling the use of data.

Individual identifiers

Health system reform mandates have generated a need to track patients over long periods of time to provide the data necessary to measure outcomes, quality, and cost. Individual patient identifiers, either numbers or codes, will be necessary. The most commonly posed solution to developing an identification system is to use one already in existence—Social Security numbers. While this is conceptually an attractive option and one endorsed by WEDI, use of SSNs presents some serious considerations. SSNs have not historically been protected by data privacy laws, and once a user has a patient's SSN, the user may also gain access to sensitive personal information, such as financial and credit data, tax filings, and employment details. The Minnesota Legislature took a first step in protecting SSNs last session by providing a specific data classification of "private" for SSNs collected for government uses. Nonetheless, it may be difficult to keep health data private with the use of such a historically "public" identifier. Privacy experts and consumer groups are already mounting forces to prevent use of the SSN as a patient identifier.

The most commonly discussed alternative is a scrambled or encrypted SSN system. Theoretically, providers would use SSNs, which would be scrambled before transmission to other users. Certain users would be granted access to the code to identify individuals. This alternative system, or any other unique identifier system, will be expensive and administratively difficult.

During the 1994 session, the Legislature determined that Social Security numbers will be used as the basis for the unique identifier in Minnesota. As envisioned in Article 9 of the MinnesotaCare Act of 1994, a patient's SSN will be encrypted twice to ensure protection and minimize any likelihood that the patient's record will be broken into. Under the law, patients may elect not to use their SSN, in which case the commissioner of health is required to issue an alternate number. In addition, providers and group purchasers cannot require patients to use their SSN and must notify patients of their ability to choose between their SSN and an alternate number. This system is to be implemented on or after January 1, 1996.

The unique identifier will appear on the front of the health care identification cards, which are to be issued to all Minnesotans with health care coverage by January 1, 1998. The standards for the cards are outlined in law and establish which elements of the card must be human readable and which must be machine readable.

continued

Federal Privacy Legislation

By Theodore M. Thompson, J.D.

Headlines from the health reform debate, both in Minnesota and Washington, D.C., have focused on integrated delivery systems, universal coverage, employer mandates, and the political intrigue commensurate with reform of the magnitude envisioned. A key element that rarely receives media coverage, let alone a headline, is that of data privacy in a reformed system.

Rep. Gary Condit, D-California, chair of the Subcommittee on Information, Justice, Transportation and Agriculture of the House Government Operations Committee, introduced in March H.R. 4077, the "Fair Health Information Practices Act of 1994," to establish a code of fair information practices for the use and disclosure of health information that originates in or becomes a part of the health treatment or payment system. Condit introduced the legislation with the intention of amending it onto President Clinton's health reform bill.

The proposal would establish uniform federal rules applicable to all health information, thereby preempting state law. The bill specifies the responsibilities of those who collect, use, and maintain health information about patients; defines the rights of patients; provides for enforcement mechanisms; limits how much information can be disclosed; and specifies other rules related to health information practices. "Health use trustees," "public health trustees," and "special purpose trustees" are defined and given certain duties and authority for dissemination of health information. Enforcement mechanisms include criminal penalties of up to 10 years, civil remedies for aggrieved patients, and civil money penalties that may be imposed by the secretary of Health and Human Services.

The need for comprehensive federal regulation of health information was highlighted in the Office of Technology Assessment report "Protecting Privacy in Computerized Medical Information," which concluded that current state and federal laws do not adequately protect the privacy rights of patients. It noted that problems will be exacerbated in the future as more health information is stored in non-paper formats.

In May, Condit's subcommittee held hearings on the "Fair Health Information Practices Act of 1994," but as *Minnesota Medicine* went to press, the bill had not been reported out of subcommittee. It appears for the moment that as federal health system reform goes, so goes H.R. 4077.

Theodore Thompson is legislative counsel for the MMA.

Access

The security of data stored in any database is questionable. Who will have access and under what circumstances? Currently, access to medical records is handled manually, and patient consent is usually required under Minnesota law. Even so, most patients are not aware of how many people and entities really have access to their medical information. With EDI, ready access to data will increase significantly, while patients' control over access will likely diminish.

In Minnesota, the Legislature is attempting to make individuals more aware of which entities have access to their medical records. Minnesota Statute §144.335, the Access to Health Records Statute, was amended this year to require providers to notify their patients about practices and rights regarding access to records by the patient and others. The commissioner of health is required to develop standard language for the notice.

One of the advantages that may result from computerization is that access to data may be narrowed to the specific item of information the user needs; this will avoid unnecessary copying and mailing of entire patient histories. In addition, evolving technologies such as an "audit trail," the computerized version of a "paper trail," may provide more reliable privacy protection. Computers will track requests for information from the database, and, as a result, will more accurately document the data released. Currently, there is often no record of the release.

Accuracy

Concern also exists over how well the system will actually maintain control of very large volumes of information. Incomplete, inaccurate, or out-of-date information could create significant problems in a variety of areas, including patient care. Concern about the accuracy of medical records is not new. With the use of a centralized database, however, inaccuracies may become more widespread simply because of the volume of data processed and the procedures necessary to load the data on the system.

Quality assurance procedures must be established to minimize the potential for error. This will necessitate ongoing provider involvement. Regular attention to the reliability and validity of the database will be a necessary component of maintenance, likely increasing the administrative burden on physicians.

Use

With the new data will come new uses and new users. Who will control use of the data? Will drug companies, for instance, be able to buy data to develop new products and then use the data to market the products to specific populations? Should health insurance companies be allowed to use the data to develop and execute marketing? The idea that the information-broker industry may tap this new source of valuable data is a fear that must be considered. And what about employers' use of the data? Will employers be able to obtain data on employees and possibly exclude them from their positions based on health status? Input from data system security experts will be key to avoiding unauthorized use. But most important are the policy decisions that must be addressed before implementation of the data system.

On a positive note, the data will have many valuable uses. Providers may use the data to develop clinical guidelines. Employers and purchasers may use the information to measure the health status of employees or plan members and to design programs tailored to these populations' health care needs. Many such activities are currently underway. An expanded data collection effort will create more opportunity for new and better uses of data.

Conclusion

Data collection and dissemination is a major theme in both state and national health system reform. On a conceptual level, the promise of providing better measures of health status and ultimately improving the public health is desirable. Just how this translates into data collection and dissemination, however, involves very complicated concerns regarding data privacy. As health system reform moves forward and electronic transmission of patient records becomes standard methodology, we enter uncharted waters, necessitating serious thought on how to balance the needs of individuals and the public. Some people will view the transmission of medical records through electronic data interchange as a challenge to the sanctity of patient privacy. However, a more appropriate view may be one that cautiously recognizes the necessity of such systems for evaluating public health status. It will be incumbent upon interested parties to get involved in the debate determining the way electronic data interchange moves forward and legislation develops. MM

Andrea Walsh and Shirley Qual are attorneys with the law firm of Popham, Haik, Schnobrich & Kaufman, Ltd., practicing in the area of health law.

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The Monitor

News For Minnesota Physicians

Senate Committee Approves Medical Liability Cap

In a victory for organized medicine, the Senate Finance Committee on July 1 approved a health care liability reform amendment offered by Sen. Danforth, R-Mo., that would set a $250,000 cap on non-economic damages. The cap would be tied to the medical inflation rate. The 11 to 8 vote on this amendment to the committee's health reform mark-up raises hopes that liability reform may be considered by Congress this year.

On behalf of the MMA, C. Randall Nelms, M.D., MMA president, wrote to thank Danforth and other members of the committee, including Sen. Dave Durenberger, R-Minn., for their support of the cap. "The Danforth amendment is a step in the right direction as Congress grapples with reform of the entire health care system, including liability reform," Nelms wrote. "If the money spent on medical malpractice and defensive medicine was spent instead on health care coverage for the uninsured, then over 3.5 million more Americans would have coverage." According to a U.S. Office of Technology report, the cap on damages is the most effective cost-saving element of medical liability reform.

MMA Supports Grams' Medical Liability Bill

Rep. Rod Grams, R-Minn., has introduced the Medical Malpractice Fairness Act of 1994 in the U.S. House. This bill includes a cap on non-economic damages, periodic payments of future damages, and a reasonable statute of limitation.

The MMA worked with Grams to develop a proposal that would convert the money spent on medical malpractice costs and defensive medicine into money spent to provide health coverage for the uninsured.

On the negative side, the bill includes a mandatory alternative dispute resolution (ADR) provision. The MMA opposes mandatory ADR because where it has been tried it has generally resulted in larger awards and increased costs. Despite concerns over ADR, the MMA supports Grams' bill because it includes other important elements of tort reform.

MMA Urges Support for Patient Protection Act, Antitrust Relief

MMA leaders and staff held separate meetings to discuss national health care issues with Rep. David Minge, D-District 2, William Luther, a DFL congressional candidate, and Sen. Paul Wellstone. The MMA urged support for the AMA/Wellstone Patient Protection Act and antitrust measures, as well as for tort reform in national health system reform proposals. One objective of the meetings was to clear up possible misconceptions about the Patient Protection Act, which has encountered strong opposition from insurance companies and HMOs. The bill is not intended to undermine managed care and is not an "any willing provider" bill. Managed care plans could still set criteria to select and limit the number and specialty mix of physicians under contract. They could not, however, dismiss physicians without due process.

Announcements

MMA Officers Nominated for 1994-95

The MMA Board of Trustees accepted the following slate of nominees for 1994-95 MMA offices:

President-elect: Michael J. Murray, M.D., Rochester, current vice speaker of the MMA House of Delegates

Vice president: Raymond G. Christensen, M.D., Moose Lake, current MMA vice president

Secretary: Thomas B. Dunkel, M.D., St. Paul, current MMA secretary

Treasurer: Eric Reeber, M.D., Bagley, current MMA treasurer

Speaker of the House: Barbara P. Yawn, M.D., Rochester, current MMA speaker of the House

Vice speaker of the House: Anthony C. Jaspers, M.D., Lake Crystal, an MMA trustee representing the Southwest District

The nominee for chair of the MMA Board of Trustees is Timothy J. Crimmins, M.D., Minneapolis, an MMA trustee representing the West-Metro District.

Nominations for officers will remain open through the first session of the House of Delegates at the MMA Annual Meeting.

Broken Bones, Black Eyes, and Battered Lives

Can you identify abuse? How will you respond? Set aside Thursday, November 4, for this important MMA conference at the Radisson South Hotel, Bloomington, Minnesota.

Viewpoint

• • •

Gail L. Gamble, M.D.
Chair, MMA Board of Trustees

MMA Supports Component Medical Society Activities

Not too long ago, physicians who weren't interested in politics or socioeconomic issues could concentrate on their practice and let someone else get politically involved. There weren't many dramatic changes in the health care environment, just a few ripples on the surface.

Now we face a great tidal wave of change. It is crucial that every physician be involved in decisions that will determine the future of medicine in this state.

That is why the MMA is mounting a campaign to support our component medical societies. We need to use the talents, ideas, and energy of every physician, and the component medical societies are in the best position to help us do that.

You've seen the bumper sticker: "Think globally, act locally." We hope for a grassroots network of physicians working at the local level to affect health care in our state. Working through the component societies, the MMA will encourage physicians to work in their local communities to achieve the kind of health care system we would like to see at the national and state levels.

To that end, the MMA recently added a field representative, Steven Jahn, who serves as a liaison with the component medical societies and MMA members throughout the state. So far Jahn has met with physicians in the Twin Cities, Rochester, St. Cloud, Hinckley, Mankato, and New Ulm. He has found great diversity in the activity level of the component medical societies. Not surprisingly, the larger associations, which have staff support and large membership rolls, are more active than smaller societies with widespread membership and minimal to no staff resources.

"The MMA plans to help *all* the component societies be active and effective," Jahn says. "I will be a familiar face, someone to call if you have a concern or a question. If I can't help, I'll know who can."

Ideally, what could a local medical society do to affect health system reform?

A local medical society could affect health system reform in the following ways:

- Serve as an interdisciplinary forum to affect health system reform;
- Increase the involvement of members;
- Develop educational programs and workshops for physicians;
- Serve as a reliable source of health information for local legislators;
- Support local candidates who are health care advocates; and
- Be an active part of the MMA legislative network that links members to a specific legislator.

This may sound like a tall order for over-worked physicians, but the MMA will provide the necessary support.

It doesn't take a great deal of time to have an impact. Just five minutes of conversation with your own legislator can make a major difference. Legislators listen to the neighbor down the block, the coach of their child's baseball team, and the volunteer who helps on their political campaign more readily than they do to a stranger. Only you can explain how legislation will affect health care in your own community and give concrete examples that strike close to home.

Of course, you don't have time to become an expert on every issue. But the MMA, working with the component medical societies, will provide direction and up-to-date information.

How can the MMA help members and the component medical societies?

The MMA can help you and your component medical society in the following ways:

- Provide information about legislation and about the changing health care environment;
- Analyze what those changes mean;
- Help set up local programs and workshops;
- Enhance the MMA legislative network through training programs, the Action'94 newsletter, and information about specific legislation;
- Listen to the concerns and problems of physicians in each area and make sure their message is heard at the Legislature;
- Provide ongoing communication through publications such as *The Monitor* and *Minnesota Medicine*, and through the Hospital Medical Staff Fax, the Fax-on-Demand, and member toll-free phone line.

If we physicians are to have a voice in health system reform, we have to work together, participating in our component society and in the MMA. An organized, unified effort is essential and will work. • • • • •

MMA Annual Meeting

Schedule of Events

Radisson Suite Hotel, Kelly Inn
St. Cloud Civic Center

Wednesday, Sept. 28

11 a.m. to 6 p.m. (CC)
General registration

2 p.m. to 4:45 p.m. (CC)
MMA Board of Trustees meeting

5 p.m. to 6 p.m. (CC)
MinnesotaCare open forum

7 p.m. to 9 p.m.
Welcome reception at Pirate's Cove, Sauk Rapids
Buffet, hospitality, and cruise

CC=Civic Center
K=Kelly Inn
R=Radisson Suite Hotel

Thursday, Sept. 29

6:45 a.m. to 5 p.m. (CC)
General registration

7:15 a.m. to 9:15 a.m. (K)
County society caucuses:
- Ramsey
- Hennepin
- Greater Minnesota

8 a.m. to 8:45 a.m. (K)
Media briefing

9:30 a.m. to 10:45 a.m. (CC)
MMA House of Delegates (Session I)

10:50 a.m. to 11:45 a.m. (CC)
AMA open forum

12 p.m. to 1:15 p.m. (CC)
Awards lunch

1:15 p.m. to 4 p.m. (K)
Reference committee open hearings

4 p.m. to completion (K)
Reference committee executive session

4:30 p.m. to 6 p.m. (R)
MEDPAC Annual Meeting (R)
Hospital Medical Staff Section (R)
Young Physicians Section (R)
Women Physicians (K)

5 p.m. to 6 p.m. (R)
AMA Delegation Meeting

6:30 p.m. to 7 p.m. (K)
Pre-inaugural reception

7 p.m. to 9:30 p.m. (K)
President's inaugural dinner and festivities

Friday, Sept. 30

7 a.m. to 8 a.m. (CC)
MMA Board of Trustees breakfast meeting

8 a.m. to 12 noon (CC)
General registration

8 a.m. to 10 a.m. (K)
County society caucuses:
- Ramsey & Hennepin
- Greater Minnesota

10:15 a.m. to 3:30 p.m. (CC)
MMA House of Delegates (Session II), includes lunch

3:30 p.m. (CC)
Board of Trustees organizational meeting

Spouse Activities
12 noon (R)
Luncheon

Health System Reform Debate Moves to House and Senate Floors

Two House committees and two Senate committees have passed mark-ups of President Clinton's health system reform bill, and the debate now heads for the full House and Senate. Democratic majority leaders Rep. Richard Gephardt, D-Mo., in the House and Sen. George Michell, D-Maine, in the Senate will consult with party leaders, combine the committee mark-ups, and come up with compromise bills to be considered on the floors of both chambers. Rep. Martin Sabo, D-Minn., is actively involved in drafting the House bill. If the House and Senate leaders' bills pass, they go to a bipartisan conference committe, then back to the House and Senate for a final vote before going to the president.

If the committees' experiences are any indication, there will be sharp disagreement over employee mandates and universal coverage. Progress through the committees was slow, requiring many compromises along the way. One of the committees foundered, unable to break the deadlock over the employer mandate. The House Energy and Commerce Committee, chaired by John Dingell, D-Mich., has announced it will not report a bill. Dingell is, however, helping to draft the compromise legislation.

Clinton continues to push for universal coverage, which is included in three of the four mark-ups. But enthusiasm for universal coverage as a concept may be overwhelmed by reluctance to embrace either of the two ways to pay for it: an employee mandate or tax increases.

If health system reform does not crash upon the rocks of irreconcilable differences, it may still come up against a filibuster in the Senate. A filibuster can be broken by a vote of 60 senators. If the Democrats hold ranks, they have only 56 votes plus Vice President Gore as a possible tie breaker.

Summaries of the four committee mark-ups of the Clinton health care reform bill follow.

House Ways and Means Bill

House Ways and Means, chaired by Rep. Sam Gibbons, D-Fla., voted 20-18 to approve a bill that would achieve universal coverage by 1998 and would require employers to pay 80 percent of their workers' insurance. This bill, which includes amendments favoring fee-for-service medicine, is bitterly opposed by the HMOs. After fierce partisan debate, the bill squeaked out of committee without a single Republican vote.

The bill would guarantee that people won't lose their insurance nor be discriminated against because of their health status. Medicare would be expanded to create Medicare Part C as a "safety-net program" for small businesses with fewer than 100 employers or for people who don't have access to health insurance through their employment.

The bill would increase the current tax on a pack of cigarettes to pay for subsidies for low-income people. If cost-containment goals were not met, a commission would recommend cost-control measures to the president. If the president accepted the recommendations, they would be implemented; if he rejected them, Congress would be required to act.

The bill includes an amendment that would provide for an exception in the physician ownership and self-referral law for shared facilities and includes Patient Protection Act provisions for federal utilization review standards, due process for health care providers, and disclosure of information requirements.

Going beyond the Patient Protection Act, the bill includes a modified "any willing provider" amendment, which would require plans to accept all qualified health care providers who meet the plan's financial and quality criteria and match its patients' needs. It would also require health plans to allow all patients to go out of network for health services and would permit copayments to encourage patients to use the networks.

The original Clinton bill, the Wellstone/McDermott single-payer proposal, and a Republican alternative were advanced and defeated by the Ways and Means Committee.

Senate Finance Bill

The Senate Finance Committee, chaired by Daniel Patrick Moynihan, D-New York, passed a bill that falls short of guaranteeing everyone health coverage and rejected an employer mandate and price caps on insurance premiums. After five Democrats joined the Republicans to defeat the employer mandate, the committee voted 12 to 8 to pass a bill that would achieve 95 percent coverage by 2002. Moynihan was quoted by the Associated Press as saying, "Universal coverage is 100 percent, less what you lose in the normal confusion of life." Currently, 83 percent of Americans are believed to have health care coverage. Sen. Dave Durenberger, R-Minn., was among the committee members opposing universal coverage and the employer mandate.

Under this legislation, workers would be able to keep coverage if they changed jobs, and insurers could not deny coverage for a pre-existing condition. Subsidies for low-income people would be provided by taxes on health benefit plans and on tobacco. Health insurance cooperatives would be created to make insurance more affordable.

If market changes and subsidies for the poor didn't cover 95 percent of the public by the year 2002, a national commission would recommend further action, possibly calling for employee mandates, and Congress would have to vote on the commission's recommendations.

In a victory for medicine, the bill includes a $250,000 cap on noneconomic damages in medical liability that would increase with the medical inflation index.

After heated debate, an amend-

ment was accepted that allows any employer or health plan to exclude abortion from insurance coverage for reasons of conscience.

Princeton economist Uwe E. Reinhardt says the Moynihan compromise on health system reform is not good enough because it will leave too many Americans behind—with serious consequences in cost-shifting, benefits for the poor, and public health. In a *New York Times* op/ed, Reinhardt said that voters must tell Congress that universal coverage is important to them and it's "now or never" to make it happen.

Senate Labor and Human Resources Bill

The Senate Labor and Human Resources Committee, chaired by Sen. Edward Kennedy, D-Mass., approved a universal coverage bill that includes the core of Clinton's health care reform plan, a requirement that employers insure their workers and pay at least 80 percent of their premiums. Businesses with 10 or fewer workers whom they did not insure would pay a 1 percent to 2 percent payroll tax. The cigarette tax would go from 24 cents per pack to $1.74. Premium increases would be capped if market reforms didn't control costs. The bill calls for health care purchasing cooperatives, but membership would be voluntary for firms with 500 to 1,000 employees. The bill includes provisions of the Patient Protection Act, including due process for providers and state standards for utilization management.

House Education and Labor Bill

The House Education and Labor Committee, chaired by William Ford, D-Mich., voted out a bill that comes closest to the original Clinton proposal but has an even more generous benefit package with improved mental health and substance abuse benefits. It calls for employers to pay for 80 percent of premiums and would set limits on premium increases by 1999. The bill includes portions of the AMA's Patient Protection Act, guaranteeing physicians due process rights, providing utilization review protections, and requiring coverage disclosure. This committee also sent a single-payer bill to the House floor.

Other Reform Bills Are Proposed

Dole Bill

The major Republican bill, proposed by Senate Majority Leader Robert Dole, R-Kan., calls for insurance reforms and $100 billion over five years in subsidies for low-income families to buy private insurance. People who buy catastrophic policies with high deductibles would be able to create medical savings accounts of "before tax" money and spend it on medical costs not covered by insurance. With no tobacco tax or employer mandate, the bill relies almost entirely on savings from Medicare and Medicaid. It would create purchasing pools but only for businesses with no more than 50 workers, not large enough to have much clout. Durenberger opposes this bill, which he says will not contain costs.

Single-Payer Bill

The single-payer bill, sponsored by Paul Wellstone, D-Minn., would achieve universal coverage and be funded by the federal government with money raised by corporate and individual income tax increases. The program would be administered by the states. Provider payments would be negotiated between the states and practitioner representatives based on the Medicare relative value scale. • • • • •

MEDPAC Supports Congressional Candidates

• • • • • MEDPAC HAS RECOMMENDED that AMPAC endorse incumbent Congressional candidates Rep. David Minge, DFL-District 2, Rep. Jim Ramstad, IR-District 3, and Rep. Martin Sabo, DFL-District 5. MEDPAC also recommended support for Gil Gutknecht, IR, a Minnesota state representative and assistant minority leader in the House, whom the MEDPAC screening committee found to be the District 1 candidate most in line with medicine's and the AMA's views.

In the sixth district race, MEDPAC supports William Luther, DFL, a state senator from Brooklyn Park. Luther is a strong advocate of universal coverage but not of a single-payer plan. He supports a broad-based tax to pay for universal coverage and favors a payroll tax over an income tax.

The congressional race in the seventh district will be a rematch between Bernie Omann, IR, a former state representative from St. Joseph, and the incumbent, Rep. Collin Peterson, DFL. In the last congressional election, MEDPAC supported Omann, who narrowly lost the race. But recently, Peterson has earned high marks from the AMA for working with their lobbyists and for co-sponsoring the Health Care Antitrust Improvements Act of 1993 and the Patient Protection Act. The MEDPAC Board has not reached consensus on this race and has delayed its decision until the August meeting.

AMA Responds to 1993 MMA Resolutions

At the AMA Annual Meeting in June, the AMA House of Delegates adopted several reports that respond to 1993 MMA resolutions.

Reform Bills Must Include Research, Education Funds

In response to a 1993 Minnesota resolution, the AMA will help assure that health system reform will include adequate funding for medical education and research. The MMA resolution asked the AMA to study funding for medical education and research in the health system reform proposals being considered by Congress, develop a policy in support of appropriate funding, and report back to the AMA House.

Two reports adopted by the 1994 House respond to that request.

Health system reform, with its emphasis on cost containment, threatens research and academic health centers, warns the Council on Scientific Affairs report. "Counteracting the threat will require a multifaceted approach, including efforts at educating the public and increased vigilance as the health system reform proposals are debated in Congress."

Most of the money for medical schools comes from biomedical research funding and faculty medical practice income, the report notes. In the past, these two sources have allowed institutions enough flexibility to support medical education. But as competition for funds increases, faculty practice plan earnings and teaching hospital revenues will decline, making less money available for medical education.

The AMA House adopted the council's recommendations calling on the AMA to "take every opportunity during the health system reform debate ... to educate the public, the Administration and Congress about the importance of support for science and biomedical research. ..."

The AMA House also adopted the recommendations in the Council on Medical Education report calling on the AMA to work with the medical education community to ensure that federal and state policy-makers pay attention to the need for adequate funding for medical education.

The AMA recommends two ways to provide financial support for medical education: 1) create an all-payer funding pool for graduate medical education, and ensure that funding is distributed to the sites that are responsible for training residents; and 2) develop a federal funding pool to support educational innovation at individual medical schools. The funds could be distributed on a competitive basis through grants or contracts.

The following activities should be given priority:

- Provide graduate and undergraduate medical education in ambulatory care settings in the community and assure adequate supervision for trainees.
- Preserve the potential for educational innovation and the possibility of future change in curriculum and student/resident evaluation.
- Preserve an appropriate mix of qualified generalist and specialist faculty to serve as supervisors for medical students and residents.
- Increase the opportunity for primary care faculty members to participate in research.

The proposed health system reform bills do not address funding of undergraduate medical education and of biomedical research, according to the Council on Medical Education report. Nor do legislators seem to be aware that these areas are likely to be seriously affected by the proposed changes in health care financing.

Currently, graduate medical education is partly financed through Medicare medical education payments. The Clinton health care proposal and the committee mark-ups call for an all-payer system for funding graduate education in place of the direct Medicare medical education subsidy. This is consistent with AMA policy.

Examine Arrangements with Fee Review Companies

The 1993 Minnesota delegation asked the AMA to address the issue of financial arrangements between fee review companies and insurance or managed care companies to make sure these arrangements don't induce fee review companies to adjust coding inappropriately, thereby decreasing reimbursement to physicians and potentially jeopardizing quality of care.

Insurance companies and managed care organizations often contract with outside organizations known as fee review companies to monitor and adjust physicians' coding and billing. The AMA Board of Trustees' report recommended that the AMA encourage regulatory agencies to review these financial arrangements and that the AMA oppose arrangements structured to induce the peer review company to adjust codes inappropriately for the primary purpose of decreasing reimbursement to physicians and other health care providers. The 1994 AMA House of Delegates accepted the report and recommendations.

The 1994 AMA House also adopted a report responding to a 1993 Minnesota resolution calling for a review of violence and abuse in the medical work place, which was summarized in the July *Monitor*.

Minnesota Medical Student Elected to AMA Office

Michael Achinger, a student at the University of Minnesota Medical School, was elected to serve as the delegate of the AMA-Medical Student Section Governing Council at the 1994 AMA Annual Meeting in June. He will also serve as the student delegate to the AMA House of Delegates beginning in June 1995.

LEGAL NEWS

Court Allows Border Docs' Challenge to 2 Percent Tax

The Minnesota Supreme Court ruled June 30 that the border state physicians' challenge to the 2 percent MinnesotaCare tax can be heard, even though the physicians have not actually paid the tax. The court's ruling sends the case back to Ramsey County District Court for a decision on whether the tax on out-of-state providers is constitutional.

In 1993, before the tax took effect, physicians in Wisconsin, Iowa, and South Dakota filed a lawsuit charging that the 2 percent MinnesotaCare tax on out-of-state providers is unconstitutional and seeking an injunction to prevent the state from enforcing it. MinnesotaCare law taxes physicians outside the state who treat more than 20 Minnesota patients and uses the money to help subsidize the MinnesotaCare health insurance program for low-income families.

Without ruling on the constitutionality of the tax, the Ramsey County District Court dismissed the case because of a 1993 anti-injunction statute barring pre-enforcement tax suits.

The Minnesota Supreme Court, however, ruled that despite the anti-injunction statute, the MinnesotaCare tax raises important constitutional questions that must be adjudicated as swiftly as possible.

This ruling is good news for the border state physicians, who, according to MMA Legal Counsel Mary Prentnieks, have a strong case. The physicians argue that the tax is unconstitutional because they do not participate in Minnesota's legislative process (taxation without representation) and because there isn't a sufficient "nexus" or link between them and the state to justify the tax under the due process and commerce clauses of the Constitution.

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Physicians Lose Class Action Challenging License Surcharge

The Minnesota Court of Appeals on June 22 ruled against physicians in the appeal of their class action seeking refunds of the $400 surcharge on medical licenses issued or renewed from April 1 to September 30, 1992. The physicians argued that it was illegal for the state to require them to pay the surcharge because the tax law didn't take effect until October 1. The physicians also argued that the tax violated their constitutional guarantees of due process and equal protection.

The appeals court, however, upheld the District Court ruling in November that the surcharge was not applied retroactively because it applied to all physicians licensed under Minnesota law on the effective date of the statute, October 1, 1992. The court noted that the method of billing was only for administrative convenience—the surcharge was collected well in advance of license renewal rather than retroactively. The court based its decision on the fact that if physicians from this group did not pay the surcharge, their current right to practice medicine was not jeopardized, but they would be denied the right to renew their licenses the following year, 1993-94.

The court noted that the 1992 Legislature's passage of the tax law constituted due process. Furthermore, the court wrote that the statute does not violate equal protection guarantees because the surcharge is assessed on all physicians and the division into two groups for billing convenience is related to a legitimate state interest. The purpose of the surcharge is to raise money that will generate federal matching funds for Medicaid.

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Changes to MinnesotaCare Tax Laws Are Retroactive

The 1994 Minnesota Legislature made several changes in the MinnesotaCare tax law, which are retroactive to January 1, 1994.

• **Pass-Through Will Be Enforced.** A new law puts teeth in the requirement that all third-party payers must pay the 2 percent MinnesotaCare tax on health care services. Now all third-party payers must document their compliance with the pass-through provision when they apply for license renewal. Penalties for failure to comply can be severe. If the commissioner of commerce or health finds a third-party payer out of compliance, the company could be fined or lose its license to do business in Minnesota.

The law also makes it clear that third-party payers must pay the 2 percent MinnesotaCare tax on the entire bill, including any copayments and deductibles paid by a patient.

• **Tax Is on *Legend* Not *Prescription* Drugs.** Wholesalers are now required to pay the 2 percent MinnesotaCare tax on receipts they receive from "legend drugs" rather than on "prescription drugs." Legend drugs are defined as drugs that federal law prohibits dispensing without prescription. Prescription drugs include legend drugs and also drugs that are not required to be dispensed by prescription but which nonetheless have been prescribed.

• **Payments from Student Health Care Are Exempt From Tax.** Payments to colleges, universities, or other postsecondary educational institutions from student health care fees or activity fees are exempt from the MinnesotaCare tax. Direct payments from patients and their insurers remain subject to the tax.

ANNOUNCEMENTS

BMP Proposes Changes in CME Rules

The Minnesota Board of Medical Practice (BMP) plans to change the rules requiring continuing medical education (CME) for re-licensure of physicians. The proposed changes were published in the July 11 *State Register*. Any comments, questions, or requests for a public hearing must be received in the BMP office by 4:30 p.m. on August 12, 1994.

The major proposed changes are as follows:

• The BMP will no longer review and approve applications for Category 1 CME credit. This is a change from current rules that allow any person or organization to apply to the BMP for approval of credit. The change will standardize the definition of Category 1 in Minnesota by eliminating the current BMP definition, which differs from that of the AMA. The BMP's acceptance of the AMA's definition of Category 1 CME credit represents a move toward higher quality in CME. The BMP proposes to end its CME approval process January 1, 1995. Organizations that in the past have applied directly to the BMP for CME credit will have to become accredited or work with an organization qualified to provide AMA Physician's Recognition Award (PRA) credit or its equivalent. The MMA is qualified to provide both accreditation and CME credit.

• The new CME requirement for every three-year time period will be 75 hours of Category 1 CME credit as defined by the AMA PRA or by its equivalent such as the American Academy of Family Physicians or the American Osteopathic Association. Categories 2 through 5 as defined by the BMP will be eliminated. The new CME requirements for physicians will apply to three-year time periods beginning on or after January 1, 1995. Physicians will be required to report their CME credits at the end of the three years.

If you have questions, or if you would like a copy of the proposed rules, please call Jane Phillip at the MMA at 612/378-1875 or 800/999-1875.

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MMA Announces CME Planners Conference

The MMA Committee on Accreditation and Continuing Medical Education (CME) invites everyone involved in CME planning to its Third Annual Conference October 21 at the Northland Inn in Brooklyn Park.

Topics for the day-long conference include discussion of new technologies, potential effects of health care reform on CME, and an update on CME requirements for physician re-licensure in Minnesota. An interactive audience response system will allow participants to communicate with the faculty and receive immediate feedback. There will be time to meet and share ideas with other CME planners. Watch the mail for further details.

The Minnesota Medical Association (MMA) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The MMA designates this continuing medical education activity for 6.5 hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

For futher information, call Jane Phillip, Minnesota Medical Association, 612/378-1875 or 800/999-1875.

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CISN Applications Are Available

The Minnesota Department of Health is now accepting applications to form community integrated service networks. CISNs may begin operations January 1, 1995. If you would like to request an application or if you have questions about the application procedures or the documents that will be needed, call Tom Johnson at MDH Health Care Delivery Systems, 612/282-6333 or 800/657-3916. Or you may write to him at 121 East Seventh Place, P.O. Box 64975, St. Paul MN 55164-0975.

If you have questions about how to establish a provider network or how to select a consultant, or if you would like a list of people and companies that can assist you, contact Chari Konerza at the MDH Office of Rural Health, 717 Delaware Street S.E., Minneapolis, MN 55414. Her phone number is 612/623-5282.

The Monitor
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Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. Mayo Clinic Proc 1986;61:859-64.
2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. Dis Colon & Rectum, to be published.
3. Chaterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.
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Central Neurocytoma

Diagnosis and Treatment

Bradley E. Weprin, M.D., Walter A. Hall, M.D., and Thomas A. Bergman, M.D.

ABSTRACT

Central neurocytoma is a rare intraventricular brain tumor that affects young adults and presents with nonspecific signs and symptoms. This distinct clinicopathological entity has a benign biological behavior with good prognosis following surgical intervention. Two cases of central neurocytoma are presented and the diagnosis and treatment discussed.

Historically, intraventricular tumors have been thought to originate from ependymal cells or the choroid plexus. However, Hassoun et al. described in 1982 two cases of histologically benign intraventricular tumors that displayed neuronal differentiation, which they called central neurocytoma. The tumors resembled oligodendrogliomas or ependymomas on light microscopy but revealed neuronal features on electron microscopy and immunohistochemical analysis.[1] Although the number of reported cases of central neurocytomas is increasing in the neuroscience literature, this tumor remains unknown to most clinicians.

Case 1

A 28-year-old man presented five months after a motor vehicle accident with progressively worsening occipital headaches, blurred vision, double vision, and recent memory loss. Neurologic examination demonstrated short-term memory loss, bilateral papilledema, and a left sixth nerve palsy.

Computed tomography (CT) of the head revealed a large midline, multicystic, partially calcified intraventricular mass. Magnetic resonance imaging (MRI) better delineated the mixed solid and cystic lesion located in the third ventricle that measured approximately 5cm x 7cm. The tumor was enhanced by gadolinium-DPTA administration, and significant hydrocephalus was present.

We resected the patient's tumor by a transcortical approach. Preliminary examination on frozen section was suggestive of oligodendroglioma.

Following surgery, the patient's headaches resolved. Cognitive impairment manifest as recent memory loss improved to the preoperative level on comprehensive neuropsychological evaluation. Several months after surgery, the patient returned with intermittent visual blurring and persistent hiccups related to ventricular dilatation and was treated with ventriculoperitoneal shunt placement. Postoperative MRI studies show no evidence of tumor recurrence after more than one year.

Case 2

A 30-year-old female was referred for evaluation of a Chiari type I malformation identified during evaluation of occipital headaches of one-year duration. The patient complained that her vision had been blurred for the past two months, and she had occasional ataxia and tinnitus. Neurologic examination demonstrated bilateral papilledema.

Computed tomography of the head revealed a sharply defined cystic and calcific mass within the right lateral ventricle and associated hydrocephalus. Magnetic resonance imaging also showed a large mass within the right lateral ventricle that measured 5cm x 3cm x 3.5cm and infiltrated the septum pellucidum. Calcification and abnormal flow voids were apparent within the enhancing mass.

This patient was taken to the operating room, where we performed gross total resection via a transcallosal approach. Histological examination of the frozen sections revealed a small cell neurocytoma.

Following surgery, the patient had mild left-sided hemiparesis due to brain retraction, which gradually resolved. Her preoperative headaches have also improved, and she showed no radiographic evidence of recurrence after one year.

Discussion

The true incidence of the central

neurocytoma is difficult to estimate, but it may represent more than 0.1% to 0.5% of all brain tumors.[2,3] The differential diagnosis for this tumor includes oligodendroglioma or ependymoma, and the terms intraventricular and differentiated neuroblastoma have been applied to these lesions.[4-7] Central neurocytoma is a distinct clinical and pathological entity that is different from other central nervous system tumors because of its benign biologic behavior and the associated good prognosis.

Most reported cases affect men and women in their third and fourth decades, but the age range at presentation is six to 66 years.[7,8] Clinical symptoms reflect associated hydrocephalus and elevated intracranial pressure. Headache, nausea, and emesis are the most common complaints, and papilledema is frequently found on physical exam. Visual and mental disturbances are occasionally reported. Neuroendocrine dysfunction, such as amenorrhea and gigantism, have been described.[5,9,10] Focal neurological deficits are uncommon. Symptoms are usually present for several months, with some central neurocytomas identified incidentally.[11,12] These tumors may be present long before symptoms related to hydrocephalus develop. In the cases we describe here, both patients were young and presented with nonspecific complaints related to ventricular obstruction for up to a year. Their neurological examinations were notable for bilateral papilledema and the absence of other sensorimotor deficits.

Radiographically, central neurocytomas can be located in one or both of the dilated lateral ventricles with occasional extension into the third ventricle. Computed tomography will show a round, well-circumscribed, isodense or slightly hyperdense intraventricular mass with rare parenchymal invasion. Coarse calcification and foci of cystic degeneration are frequently seen within the tumor, and intratumoral hemorrhage is occasionally present. Minimal to moderate enhancement occurs after the administration of intravenous contrast.[13] On MRI, central neurocytomas are isointense on T1- and T2-weighted images. Intratumoral signal voids can represent blood vessels or calcification. The tumor enhances homogeneously after contrast administration. Magnetic resonance imaging is superior to CT for defining the precise location and the site of attachment for these tumors.[14] However, MRI does not demonstrate calcification or intratumoral hemorrhage as well as CT.[13] Vascularity, which is well demonstrated by angiography, does not aid in diagnosis. Both of our cases demonstrated characteristic CT and MRI features (see Figure 1).

Pathology

Grossly, these tumors are friable, well-circumscribed, and moderately vascular without invasion of the cerebral parenchyma.[15] Sites of attachment include the septum pellucidum, fornices, walls of the anterior lateral ventricles, corpus callosum, roof of the third ventricle, and choroid plexus.[11] In the cases we report, the tumors were friable and soft with increased vascularity that arose from the septum pellucidum (case 1) and the right lateral ventricular wall (case 2).

Histologically, central neurocytomas resemble oligodendrogliomas or ependymomas with a uniform population of small cells surrounded by a fine fibrillary matrix. Thin capillaries are often intermingled within the stroma. Prominent acellular areas resemble the pseudorosettes of ependymomas or the Homer-Wright

Figure 1—Case 1. Axial gadolinium-enhanced T1-weighted magnetic resonance image of the head showing a midline cystic mass and hydrocephalus.

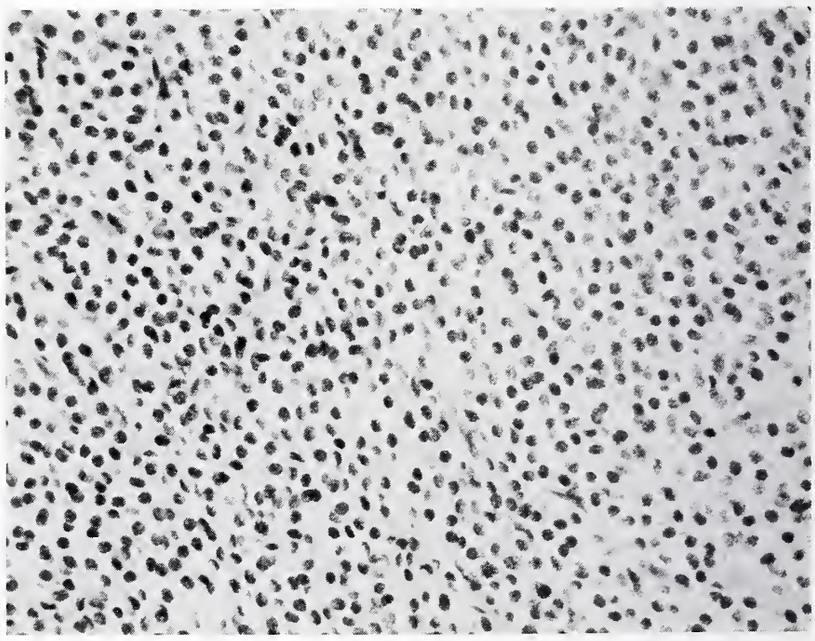

Figure 2—Case 1. Histological appearance of central neurocytoma. A uniform population of cells with round nuclei surrounded by fibrillar stroma is present (hematoxylin and eosin stain, x300).

rosettes of neuroblastomas.[4,5,8,12,16,17] The neoplastic cells have a central round nucleus, finely stippled chromatin, and an inconspicuous nucleolus. Clear, weakly eosinophilic cytoplasm is scant with ill-defined borders, giving the appearance of perinuclear halos reminiscent of the oligodendroglioma. Mitotic figures, nuclear atypia, vascular endothelial proliferation, and necrosis are rare, but microcalcifications are often seen. In both of our cases, the tumors had hypercellular areas compartmentalized by a fibrillar stroma and capillary network. The cells had prominent perinuclear halos and oval nuclei with finely granular chromatin and small nucleoli (see Figure 2). Few mitoses and no areas of necrosis were present, affirming the benign histological appearance of central neurocytomas.

Pathological diagnosis requires ultrastructural examination, immunohistochemical analysis, and to a lesser degree, light microscopy. Electron microscopy demonstrates the neuronal differentiation of the neoplastic cells by their numerous cell processes. Within these processes, microtubules are arranged in parallel, and membrane-bound, electron-dense or lucent vesicles are observed. Occasionally, microtubules and neurosecretory granules, which are rarely seen in non-neuronal tumors, are identified within the sparse cytoplasm. Well-formed or abnormal synapse-like junctions may be observed.[15] The degree of differentiation within these tumors may vary without influencing the clinical course.

In our first case, poor ultrastructural features were present, although the cytoplasm did display electron-dense material within lysosomal structures suggestive of neuromelanin, supporting the neuronal origin of this tumor. Under electron microscopy, neoplastic cells in our second case displayed the characteristic central round nuclei, dispersed chromatin, small nucleoli, and sparse cytoplasm with abundant organelles and microtubules. We observed aligned microtubules and neurosecretory granules (see Figure 3) within the cytoplasm. Cell junctions were poorly developed.

The absence of a characteristic staining pattern has led to the use of immunohistochemical techniques to confirm the neuronal nature of this tumor. Neurocytoma cells can exhibit immunoreactivity with synaptophysin, a structural component of synaptic membranes and neuron-specific enolase (NSE), a nonspecific neuronal marker. S-100 and neurofilament protein are other neuronal-marker proteins that can react with neurocytoma cells. Glial fibrillary acid protein, a marker for glial cell lineage, will identify normal astrocytes within the tumor and may be used to distinguish neurocytoma cells from the cells of glial tumors.[18] Immunoperoxidase staining was positive for NSE in our first case; staining for S-100 and synaptophysin was present in our second case.

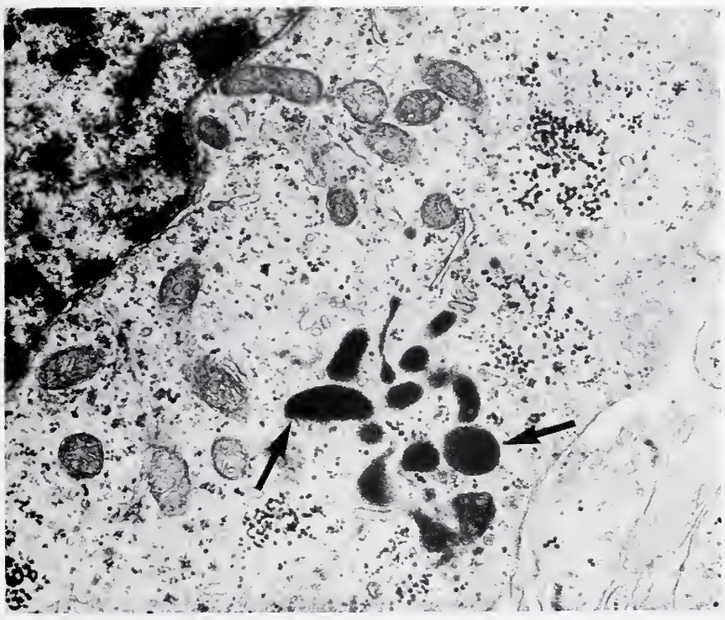

Figure 3—Case 2. Electron microscopy of the neurocytoma cell shows dense neurosecretory granules (arrows) within the cytoplasm (x49,920).

Surgical Therapy

The surgical treatment of the central neurocytoma has focused on obtaining tissue for diagnosis and relieving hydrocephalus. Tumor resection can be performed through a transcallosal or a transventricular approach. Incomplete tumor removal has occurred because of profuse bleeding or poor exposure of the tumor. Complications include focal deficits related to brain retraction, persistent hydrocephalus requiring ventriculoperitoneal shunt placement, and death following postoperative intraventricular hemorrhage or epidural hematoma formation.[3,6,8,19,20] Because of the indolent clinical behavior of the central neurocytoma, postoperative radiation therapy is controversial and usually unnecessary. Radiation therapy has been given to patients with tumors initially thought to be oligodendrogliomas or ependymomas and to patients with large postoperative residual disease. Tumor regression and disappearance have been documented following radiation therapy, although many patients remain stable for prolonged periods without adjuvant therapy.[2,3,9-11,14,21,22] Two cases of recurrence 18 months and three years after initial resection were successfully treated with radiation alone and surgery and radiotherapy, respectively.[2,3] Chemotherapy has been used in two patients.[23] Neither of our patients received postoperative radiotherapy.

Summary

In summary, central neurocytoma is a distinct clinicopathological entity characterized by an intraventricular location and symptoms related to hydrocephalus. This tumor resembles other tumor types on light microscopy, necessitating the use of other histopathological techniques to confirm neuronal lineage. Because of this tumor's benign biologic behavior and its associated good prognosis, surgery alone is the treatment of choice without postoperative chemotherapy or radiation therapy. At this time, radiation therapy is reserved for tumor recurrence, associated anaplasia, or minimal partial resection.

continued

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DUNN

(continued from page 7)

(an organization with which she is involved) illuminates the value of the current technology. One recent study by this research group suggests that the longevity and the quality of survival from certain types of brain tumors are related to the amount of tumor removed with surgery.

"Quality is the key word, because if I move out into that perimeter zone, and I start taking tissue away and it has function, then I might have a patient who can't move her arm or leg or can't speak, so I haven't done her any favors," says Dunn. "My objective is to prolong life in a meaningful way, and this technology is helping me do that."

Dunn cites the case of a patient in his 20s with three small children who works in the communications/engineering field. He underwent mapping and then returned to the OR, where 94 percent of his tumor was removed. Assisted by the computer, Dunn removed tissue within one millimeter of his speech center. Two days after the second procedure, this patient was working on his lap-top computer and interacting with his office. He was back on the job full time two weeks after surgery and did not require any adjunctive therapy. His long-term prognosis is excellent, says Dunn. Even today, the patient's treatment at many centers would have included biopsy, limited tumor removal (30 to 35 percent), and radiation therapy, which has significant long-term side effects, she says.

Dunn points out that mapping is not necessary when the tumor is clearly not intruding into functional areas (the right frontal lobe pole or right temporal lobe, for example) or with some deep tumors. If the clinical trials in which Dunn is participating are successful, mapping in the future will involve magnets, instead of the grid, placed on the brain's surface to stimulate and find function. For Dunn, who views herself first and foremost as an advocate for her patients, providing the same accuracy and dependability with one less surgical procedure is an exciting prospect.

Although Dunn is a computer technology enthusiast (she admits to being a "Star Trek" fan, as well), she emphasizes that computers can't reproduce human feelings, instincts, judgments based on cumulative experience, or creativity and imagination.

"Computers are better at mechanical bits like adding up 100 numbers, but the human is still an essential part of the process," she says. "For example, by dialing up and transferring digital information by modem, I can have an on-line consultation from the OR with an expert across the country if I run into something I know instinctively is a little bit odd." But, Dunn stresses, "It's the person, not the computer, I consult with. And, my sixth sense—something that no computer can duplicate—is always with me in the OR, maintaining a valuable presence and helping me keep my complication rates low."

Although Dunn does not believe that computers will ever replace humans, she concedes that space-age technology is fast becoming an invaluable asset in the medical world. She explains that in addition to computer-assisted neurosurgery, similar technology is now being used in the direct application of radiation sources in radiosurgical units around the country, enabling patients to receive the most radiation where they need it and the least radiation where they don't want it.

Dunn, acutely aware of the importance of cost-effectiveness (she majored in economics as an undergraduate at Arizona State University and obtained enough credits for a master's degree), declined her administration's offer to fund a radiosurgical unit at United. She says she couldn't justify the $600,000 price tag, considering that only about 10 patients (out of the 200 treated annually) at United would need that technology. In addition, patients could be sent to units at the University of Minnesota and Mayo Clinic, which currently are not fully utilized.

With 35,000 adults annually diagnosed with brain tumors and a steady increase in the number of brain tumors in all age groups, Dunn predicts that brain tumors will be a significant medical concern by the year 2000 and believes patients must be treated with cost-effective, quality care. She is wary of the current health care climate, in which the sole emphasis is on the bottom line, and she warns against losing sight of quality issues. She lauds Dan Foley, M.D., vice-president of medical affairs at United, whom she quotes as saying, "When the bottom line is the patient, all other things fall in line."

Dunn, the 38th woman in this country to become board certified in neurosurgery, began her internship convinced she wanted to be a pediatric cardiac surgeon and changed her mind when she rotated through neurosurgery and discovered she enjoyed helping people of all ages with treatable disease. But equally important as medicine, says Dunn, is her family. She says her husband, Gregory F. Cotterell, M.D., J.D., "brings together all his talents and training" as an emergency medicine physician and patent attorney. When she isn't working, Dunn's favorite activity is spending time with their 12-year-old daughter and 8- and 6-year-old sons. Dunn believes her career will have a positive impact on her kids because "they see that I enjoy my work and that it satisfies a need I have to take care of people. And, I try to help them understand what their gifts are so they can find their life's business and pursue it," she says.

At the same time, Dunn feels that being a parent and growing up with nine brothers and sisters has made her a more compassionate doctor. "I see so much courage and strength from parents of my patients," she says, "and as a parent myself, I think about how I would feel if one of my children were diagnosed with a brain tumor. I understand their difficult position and have a deep respect for what they are going through." MM

Fran Miller Toubin is a free-lance writer living in Minneapolis.

Medical Education and Health System Reform

C. Randall Nelms Jr., M.D.

The health care system in this country will not be truly reformed until medical education is reformed. If our system is truly flawed, we must go back to the drawing board—back to what shapes the system and defines the way it works.

Physicians have a societal responsibility to ensure the general welfare of people, and medical education will be judged on how well it teaches physicians to carry out this responsibility. The medical literature is filled with examples of how poorly medical education prepares physicians for their careers. Articles have been published on flawed practice standards, inappropriate utilization of technology, and the arbitrariness of practice. To properly prepare physicians, the education system must admit the right students, give them the right skills, and equip them to function in our health care system.

What is the proper preparation for the practice of medicine? Most potential medical students think more college science is the key to success, but there is no evidence that additional science provides greater insight to the practice of medicine.

A liberal arts background is the best preparation for a medical career. James M. McGreery, M.D., associate professor of medicine at the University of Utah Medical School, gives seven reasons why this is true: "1) It enhances the enjoyment of a privileged occupation, one that allows the practitioner to intervene in persons' lives in a unique and profound way; 2) It aids in the understanding of human nature and the response of individuals in crisis; 3) It provides a framework for critical decision making in problems that cannot be predicted or rehearsed; 4) It provides a refuge during life's disappointments and trials; 5) It sharpens the ability to communicate; 6) It provides an ability to recognize true quality in people; and 7) It engenders a moral fabric, an almost innate sense of what is right and what is wrong, that will foster correct decisions in dealing with human life and suffering."

"A liberal arts background is the best preparation for a medical career."

Once the right students are admitted, they must be taught the right skills. There is a growing belief that medical schools produce too many of the "wrong" kind of doctors. Currently, a small percentage of physicians take care of the majority of patients—few actually manage their patients' care as "primary" caregivers. Some people argue that teaching institutions should be responsible for ensuring that enough primary physicians are trained. Evidence is mounting that medical schools with a culture encouraging generalism breed more generalists.

Medical education reform is taking place in Minnesota. In 1992, MinnesotaCare legislation asked the University of Minnesota Medical School to increase by 20 percent the supply of primary care physicians in family practice, general pediatrics, and general medicine by the year 2000 and encourage graduates to establish practices in medically underserved areas of Minnesota.

The Minnesota Association of Public Teaching Hospitals is adjusting its curriculum requirements to meet the changing demands of society. It is requiring primary care rotations, instruction in outpatient and managed care settings, and training in nursing homes and other long-term care facilities. The rural community of Waseca, Minnesota, and the regional medical center in Mankato, Minnesota, started rural family practice residencies in July 1994.

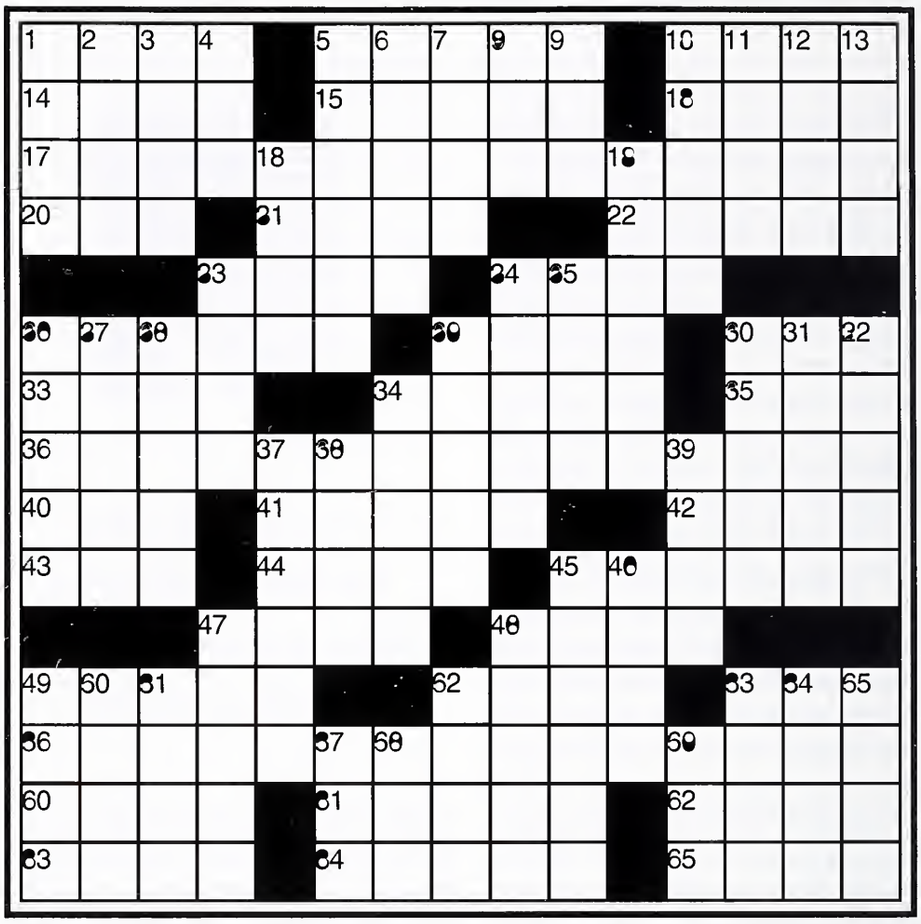
Medical education should also prepare students to practice in our communities' health care systems. President Clinton's plan proposes that the government support training programs rather than educational institutions themselves. Training programs in integrated networks or other community-based institutions could conceivably qualify for this type of support and compete successfully for funds to support research on outcomes and quality of care. Training physicians in this type of environment could equip them to function in the health care system. More medical education should be carried out in these community-based settings.

Medical education is typically supported by public funds and patient fees, and society is demanding new, improved products in return for its support. The users of our health care system want educational institutions to produce more primary care practitioners and fewer specialists, its research organizations to generate more knowledge about improving outcomes and quality, and its providers to produce health care services with increased efficiency. MM

CROSS WORD PUZZLE

By Ernest Lampert, M.D.

Internal Medicine



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ACROSS

1. Heard in CHF
5. With 22 across, causes AIDS
10. Steady pain
14. Eskers
15. Uneven
16. Popes
17. Diuretic, pl.
20. Sed. rate
21. Sound quality
22. With 5 across, causes AIDS
23. ____ to, regain consciousness
24. Ways
26. Pasteur made a vaccine for this disease
29. Feral
30. Before
33. Plinth
34. Out of dough
35. Cymbal
36. Causes wheezes
40. Erode
41. Divides into Iliacs
42. Attaches to the bit
43. Draft org.
44. Philip M. ____, U.S. novelist
45. Kind of a fist
47. Adam's third son
48. Injure
49. A votre _____
52. Slue
53. Aves.
56. May occur in CHF or TB
60. Nipa palm
61. Triangle
62. Sp. female pronoun
63. Veal or fish sauce
64. Penrose _____
65. Thoracic organ

DOWN

1. Makes hips
2. Uraeuses
3. Den
4. Sin
5. Lethal products of 2 down
6. Violet ketone
7. Actor's aim
8. Trilogy by Dos Passos
9. Part of a min.
10. Cathartic
11. Per ____
12. Cultivator
13. Exxon formerly
18. Indian
19. Swaps
23. Grafted part
24. String instrument
25. ____ Chase, author
26. Gowns
27. Tapestry
28. Present on Rorschach cards
29. Anger
30. Merman
31. Textile fiber
32. Antelope
34. Beginning
37. Profession
38. Gibson, star of silent oaters
39. Prune
45. Paganini had the syndrome named for this man
46. Japanese aborigine
47. Dated counter-irritant
48. Civilian dress
49. Nail
50. Voice range
51. Approach
52. Web
53. In ____, in place
54. Rent
55. Nylon mishap
57. Arithmetic function
58. Sea god
59. The sun

Solution on page 54

People and Places Making Medical News

People

HealthSystem Minnesota CEO

James L. Reinertsen, M.D., was named chief executive officer of HealthSystem Minnesota, the parent organization for Methodist Hospital, Park Nicollet Medical Center, Methodist Hospital Foundation, and HSM Associates. Reinertsen served as president and chief quality officer for HealthSystem Minnesota until the organization decided to simplify its structure from two co-presidents to a single CEO position after Robert L. Galloway, who served as co-president with Reinertsen, announced his retirement. Reinertsen also plans to maintain his practice with Park Nicollet Medical Center's rheumatology section.

Fairview Physician Associates Network President

Robert W. Burmaster, M.D., has been appointed president of Fairview Physician Associates Network. Burmaster will leave private practice as an internist with Consultants-Internal Medicine, P.A., to assume the new position. The Physician Associates Network is an integrated practice network that brings independent physician groups together to function as a large group practice.

Appointees to Minnesota Specialty Physicians

James Allen, M.D., and **Burton Schwartz, M.D.**, were both appointed to the Minnesota Specialty Physicians Executive Council. Allen is the director of the Memory Clinic and president and medical director of the Minneapolis Clinic of Neurology, Ltd., in Golden Valley. Schwartz is president and medical director for Oncologic Consultants, P.A., in Minneapolis.

PreferredOne Executives

Three new executives have joined PreferredOne in strategic planning and product development. **Michael Umland** has left his position as manager of financial planning and analysis at Fairview Health System to become vice president of finance and administration at PreferredOne. **Loren Hanson** is the new vice president of dental programs. Hanson previously served as executive vice president with Delta Dental. **Paul Geiwitz** is the new vice president of strategic development. He previously had been senior director of actuarial services at HealthPartners since 1992.

Najarian Sues University

The University of Minnesota's former chief of surgery, **John Najarian, M.D.**, filed a suit requesting that the university's investigation of academic misconduct be called off until a federal grand jury investigation is complete. Najarian's suit in U.S. District Court for the postponement of the university's investigation was filed because he was concerned that information given to the university in his defense could be used against him in a criminal trial if he is indicted by the grand jury. Najarian has refused to take part in the academic misconduct hearings, which began this past spring. The results of the hearings could lead to his termination from the university. Najarian is a central figure in last year's Anti-Lymphocyte Globulin (ALG) scandal at the university.

The Minnesota Court of Appeals ruled in a separate case that the University of Minnesota and its officers have full immunity from defamation lawsuits for behavior and action taken in their proper public roles. Although Najarian's suit is not a defamation suit, it did make a declaration that University President Nils Hasselmo and others made statements that may harm Najarian's chances of getting a fair hearing in the academic misconduct proceedings. The immunity ruling may help the university defend itself against Najarian's accusations.

Health Book Award Winner

William E. Walsh, M.D., founder of ACA Publications, Inc., and an allergist at Adult & Child Allergy, P.A., won an Award of Merit for his book, "Treating Sinus, Migraine, and Cluster Headaches, My Way," from Midwest Independent Publishers Association. The award, for Best Health/Fitness/Wellness book, was given to ACA Publications at the association's third national celebration in June.

Places

Mayo School of Nursing Closes

The Practical School of Nursing at Saint Marys Hospital in Rochester, which is part of the Mayo Medical Center, will be closing because of a lack of demand for licensed practical nurses (LPNs). The Mayo Medical Center hasn't hired a graduate from the school in two years, relying instead on hired registered nurses (RNs) for its needs. The school's June 30 graduation ceremony was its 46th and its last.

St. Paul-Ramsey Opening New Burn Center

St. Paul-Ramsey Medical Center will open the country's newest

regional burn center in early September. The 27,000 square-foot addition to the hospital will include space for 24 beds, on-site rehabilitation facilities, an outpatient clinic, and more room for family members of hospitalized burn patients. The center, which treats about 1,700 burn patients per year, is increasing its size by nearly three times.

In October, the Burn Center at Ramsey will sponsor a three-month photographic exhibit at the Science Museum of Minnesota to increase public awareness of burns in children. "The Scars of Childhood" will explore the pain, suffering, and isolation felt by severely burned children.

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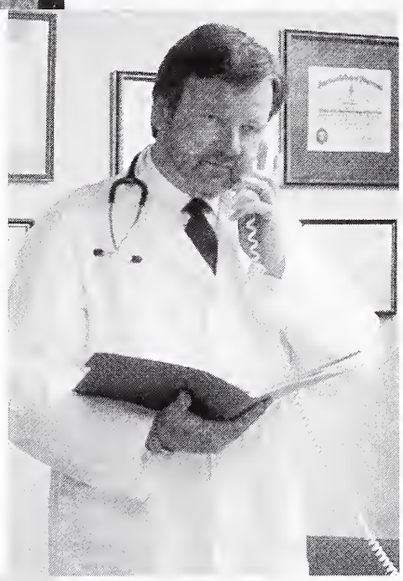

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Socioeconomics

Federal Investigation Subpoenas Minnesota Hospital Records

The inspector general of the U.S. Department of Health and Human Services has subpoenaed records from the Mayo Clinic, Saint Marys Hospital in Rochester, Rochester Methodist Hospital, and Medtronic in a federal investigation delving into possible illegal Medicare reimbursement for using medical devices not yet approved by the FDA. HHS requested replies by August 8.

Medicare is not supposed to reimburse for devices that are under clinical testing, although private insurers may. The investigation could lead to penalty fees of twice the price of the device plus $2,000 per case.

UHC and VHA Reach Agreement

United HealthCare Corp. and VHA Inc., a network of more than 1,000 hospital-based systems, have signed a three-year deal for UHC to provide managed care services to VHA members. The agreement allows VHA institutions to buy information technology applications from UHC, which owns or manages 20 HMOs. The applications available include electronic data systems linking physicians, providers, and hospitals; telephone-based utilization review; and case management services.

Children's Hospitals Finalize Merger Plans

Minneapolis ChildCare, Inc., and Children's Health of St. Paul, parent companies of Minneapolis Children's Medical Center and Children's Hospital of St. Paul, have approved a final agreement to merge. The organizations are now

under one parent company, the name of which will be announced this summer.

Mayo and Medical Associates Affiliate

Mayo Clinic has announced plans to affiliate with Medical Associates, P.C., a four-physician family practice clinic in New Hampton, Iowa. The clinic will be named New Hampton Clinic—A Mayo Regional Practice. Its physicians and staff will be considered employees of Mayo.

Met Life and Travelers Merge

Metropolitan Life Insurance Co. and Travelers Inc. have announced a merger that will create the nation's largest health care insurance company, serving 13 million people. This merger follows a recent trend among health care companies, which have been merging to achieve economies of scale to maintain competitiveness.

Kennett Simmons, former chair and chief executive of United HealthCare Corp., will head the new company.

Seven Health Plans Agree to File Claims Electronically

Seven Minnesota health plans have signed agreements to reduce costs and improve service in the health care industry by filing claims electronically, instead of on paper. The six separate agreements call for Blue Cross and Blue Shield of Minnesota to serve as an electronic claims clearinghouse for the seven organizations: Northwestern National Life's Health Management Corp., Minneapolis; PreferredOne, Minneapolis; Federated Mutual Insurance Company, Owatonna, Minnesota; Employers Health Insurance, Green Bay, Wisconsin; IMCare, Grand Rapids, Minnesota; and First Plan, Two Harbors, Minnesota.

District Memorial Joins Chisago and Fairview

District Memorial Hospital in Forest Lake has agreed to become a division of Fairview Health System as part of a new regional health care system northeast of the Twin Cities. Until Fairview completes a new 28-bed hospital along Interstate 35 in Wyoming (just north of Forest Lake), District Memorial will continue to operate as an acute care hospital.

This past spring, Chisago Health Services in Chisago, Minnesota, agreed to become a wholly owned subsidiary of Fairview's new regional network.

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Solution to crossword puzzle from page 50

Rates, Trends, Data

Sex and Contraceptive Use High Among Teens

More than half of women and almost three-fourths of men have had sexual intercourse before age 18, a dramatic increase over past decades, according to a study by the Alan Guttmacher Institute. The two-year study also showed that at least 70 percent of teens who have sex use contraceptives regularly. Other findings show that nearly three-fourths of the women who had intercourse before age 14 said that at some point the sex had been forced. The abortion rate for teens dropped 25 percent over the 1980s. For babies born to mothers aged 17 or younger, three-fourths of the fathers were older than 17, often at least six years older.

The report calls for a strategy that relies on sex education, access to contraception and abortion, as well as encouragement to postpone sex.

Smoking Studies

Minnesota has the fifth-lowest rate of smoking-related deaths in the nation, while Nevada has the highest rate, according to a Centers for Disease Control and Prevention study. Utah's rate is the lowest in the nation. The study also found that 20 percent of all deaths in 1990 were caused by smoking. Minnesota, Wisconsin, Iowa, North Dakota, and South Dakota had rates among the 10 lowest in the nation, led by Minnesota with 295.2 smoking-related deaths per 100,000.

Another study, published in the June 22 *Journal of the American Medical Association*, found that one-fourth of smokers who used a nicotine patch were still not smoking six months later. This compares with about one-tenth of those who used dummy patches. The study, conducted at the Center for Tobacco Research and Intervention at the University of Wisconsin, analyzed data from 17 other studies involving more than 5,000 smokers.

Also of note, a study by the Centers for Disease Control and Prevention showed that smoking costs the United States $50 billion a year in medical care, 54 percent of which is from hospitalization alone. Taxpayers paid 43 percent of the $50 billion.

Law & Policy

Supreme Court Upholds Clinic Buffer Zone

The Supreme Court ruled that an abortion clinic in Melbourne, Florida, could retain a Florida state court injunction that created a 36-foot buffer zone around the clinic to keep protesters from blocking entrance. Abortion opponents say the buffer impedes their right to free speech, but the court decided that the right of a patient to freely enter the clinic is equally important. The court also retained a ban on excessive noise during business hours to protect the well-being of patients. The court struck down a 300-foot buffer zone around the clinic and employees' homes.

Out-of-State Providers May Sue for 2 Percent Tax

According to a recent ruling, out-of-state physicians can once again challenge the MinnesotaCare 2 percent provider tax. The Minnesota Supreme Court ruled that physicians in Wisconsin, Iowa, and South Dakota can challenge the state's right to collect the tax from out-of-state providers, even though these providers haven't paid the tax or were not billed by the state. Minnesota officials had challenged the lawsuit, citing a provision in state law prohibiting a legal challenge until the tax has been paid or the party has been billed.

Medical Research

New Hantavirus Found in Midwest

University of Wisconsin researchers have found a new hantavirus present in rodents in Duluth,

Minnesota, and Superior, Wisconsin. The hantavirus is suspected to be similar to the virus that killed at least 42 people last year in the Southwestern United States. The discovery of the new hantavirus is no cause for alarm, however, since it appears to be benign, according to Michael Osterholm, state epidemiologist at the Minnesota Department of Health, in a recent Minneapolis-based *Star Tribune* article. There has only been one case of the virus in Minnesota, and the victim survived.

Breast Implants May Not be Linked to Illness

Mayo Clinic researchers found no link between silicone breast implants and connective-tissue diseases, cancer, inflammatory arthritis, or other disorders commonly associated with implants, according to a study published in the June 16 issue of the *New England Journal of Medicine*. The study examined 749 Olmsted County women with implants and compared their risk with 1,498 women without implants.

An estimated 1 to 2 million women in the United States have received the implants. Questions about the implants' safety began surfacing in the late '80s, eventually resulting in hundreds of lawsuits from women who blamed their illnesses on the devices. The Food and Drug Administration banned the implants in January 1992.

Women May Benefit From Breast Conservation Therapy

Women with early-stage invasive breast cancer may benefit from choosing breast conservation therapy, according to a study in the June *Mayo Clinic Proceedings*. The research, led by Mayo Clinic radiation oncologist Thomas Pisansky, M.D., reviewed 165 cases where women avoided mastectomy by having the tumor removed and following up with radiation therapy. This therapy results in minimal risk of tumor recurrence and may help patients in their psychological adjustment and acceptance of treatment, the study showed.

Placing Infants on Backs or Sides Can Help Prevent SIDS

Data from Australia, Great Britain, the Netherlands, New Zealand, and Norway have sparked a new national campaign to decrease the number of fatalities from sudden infant death syndrome (SIDS). The data suggest that putting babies to sleep on their backs or sides, rather than their stomachs, may help reduce SIDS deaths. State and local health officials have joined the campaign, which is aimed at the general public.

Autologous Bone Marrow Transplants Increase Longevity

Self-donor or autologous bone marrow transplants can increase the life span of adults with chronic myelogenous leukemia, according to Philip McGlave, M.D., a University of Minnesota cancer specialist. In the June 10 *Lancet*, McGlave reported that 125 of 200 people with this form of leukemia were alive eight years after undergoing an autologous transplant. McGlave said that for conventional therapy, the average length of survival is three and one-half to four years. Researchers have known for some time that *donor* marrow transplants help prolong life expectancy of CML patients, but suitable donors are hard to find.

Hope for Lyme Disease Vaccine

Scientists are continuing testing for a Lyme disease vaccine using 10,000 volunteers in five states: Connecticut, Massachusetts, New Jersey, New York, and Wisconsin. Half the volunteers received the vaccine and half received a placebo. In the fall, scientists will compare the two groups for the number of Lyme disease cases. If the vaccine works, scientists from Connaught Laboratories Inc. in Pennsylvania will submit the test results for FDA approval, and the vaccine could be available for use in two to three years.

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AIDS Update

FDA Considers Home AIDS Tests

An FDA panel has recommended approval of home blood tests for the AIDS virus. If David Kessler, M.D., commissioner of the FDA, follows the panel's recommendations, the home blood test (for use by the public) and a saliva-based AIDS tests (for use by trained paramedics) could be available within the next year. Former U.S. Surgeon General C. Everett Koop has called for immediate use of the home blood test. Proponents of the test hope it will help improve access for the poor and members of minority groups, yet others are concerned the test's $30 to $40 cost will inhibit use. There are also concerns about how to counsel those who are distraught after a positive home test. The test would require the user to send a blood sample to a lab and later call for the results. MM

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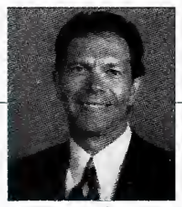

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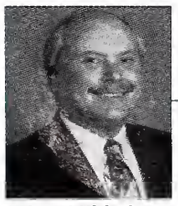

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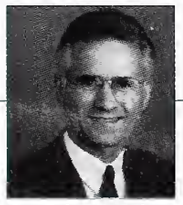

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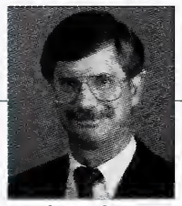

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AUGUST 1994

August 8-12 **Psychopharmacology Consultations • AIDS/HIV Prevention, Therapy, and Mental Health Consultation Issues** Psychotherapy Center at Columbia Hospital and the Department of Psychiatry at the Medical College of Wisconsin; Egg Harbor, WI. CONTACT: Carlyle H. Chan, M.D., Summer Institute Director, Psychiatry Department, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, WI 53226; 414/257-5995.

Aug. 22-Sept. 2 **Twelfth Annual Occupational Health and Safety Institute** St. Paul-Ramsey Medical Center; University of Minnesota, Mayo Building, Minneapolis, MN. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

SEPTEMBER 1994

Sept. 9-10 **Disaster and Hazardous Materials Management Conference** Hennepin County Medical Center/Hennepin Faculty Associates Office of Academic Affairs and University of Minnesota; St. Cloud Civic Center, St. Cloud, MN. CONTACT: Ann Samways, CME Coordinator, 612/347-2078; or Robin Hoppenrath, Manager, Office of Academic Affairs, 612/337-7128.

Sept. 12-13 **Pediatric Emergency Medicine Course** HealthSpan; United and Children's Hospital Conference Center, St. Paul, MN. CONTACT: Annette Carlson, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7910.

Sept. 12-14 **The Norwegian-American Orthopaedic Society** Mayo Foundation; Siebens Medical Education Building, Rochester, MN. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME and International Education, 200 First Street SW, Rochester, MN 55905; 507/284-2509.

Sept. 15-17 **Practical Surgical Pathology** Mayo Medical Laboratories; Harold W. Siebens Building, Rochester, MN. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Sept. 22-23 **Domestic Violence** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Sept. 22-23 **Fourth Annual Practical Pediatrics for the Primary Care Physician** Children's Hospital of St. Paul; Children's Hospital, St. Paul, MN. CONTACT: Mickey Starr or Janet Salmey, 345 North Smith Avenue, St. Paul, MN 55102; 612/220-6109.

Sept. 23 **Contemporary Issues in Hemodialysis** Hennepin County Medical Center/Hennepin Faculty Associates Office of Academic Affairs and University of Minnesota; Sheraton Midway Hotel, St. Paul, MN. CONTACT: Ann Samways, CME Coordinator, 612/347-2078; or Robin Hoppenrath, Manager, Office of Academic Affairs, 612/337-7128.

Sept. 23-24 **The Lower Extremity Amputee: A Multidisciplinary Approach** Mayo Foundation; Mayo Foundation, Rochester, MN. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 23-25 **Annual Ambulance Medical Directors Retreat** Hennepin County Medical Center/Hennepin Faculty Associates Office of Academic Affairs and University of Minnesota; Arrowwood Resort, Alexandria, MN. CONTACT: Ann Samways, CME Coordinator, 612/347-2078; or Robin Hoppenrath, Manager, Office of Academic Affairs, 612/337-7128.

Sept. 30-Oct. 1 **Primary Care of Patients with Epilepsy** HealthSpan; United and Children's Hospital Conference Center, St. Paul, MN. CONTACT: Annette Carlson, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7910.

Sept. 30-Oct.1 **Pelviscopic Surgery Including Hysterectomy** HealthSpan; Abbott Northwestern Hospital, Minneapolis, MN. CONTACT: Don Young, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

OCTOBER 1994

Oct. 1 **Interventional Radiology** HealthSpan; Grand Hotel, Bloomington, MN. CONTACT: Don Young, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

Oct. 6-7 **Annual Forensic Science Seminar** Hennepin County Medical Center/Hennepin Faculty Associates Office of Academic Affairs and University of Minnesota; Pillsbury Auditorium, Hennepin County Medical Center, Minneapolis, MN. CONTACT: Gail Kraemer, 612/347-2075, Ext. 2125.

Oct. 6-7 **Advanced Pediatric Life Support** Hennepin County Medical Center; Hennepin County Medical Center, Minneapolis, MN. CONTACT: Rachel Knudson, R.N., EMS Training, Hennepin County Medical Center, 701 Park Avenue South, Minneapolis, MN 55415; 612/347-3638.

Oct. 7 **Glaucoma Course** HealthSpan; Phillips Eye Institute,

Minneapolis, MN. CONTACT: Michelle Hemingway, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/336-5061.

Oct. 7-8 **Family Practice Update** Hennepin County Medical Center/Hennepin Faculty Associates Office of Academic Affairs and University of Minnesota; Mall of America Grand Hotel, Bloomington, MN. CONTACT: Ann Samways, CME Coordinator, 612/347-2078; or Robin Hoppenrath, Manager, Office of Academic Affairs, 612/337-7128.

Oct. 8 **Current Trends in Ophthalmology** HealthSpan; Hotel Sofitel, Bloomington, MN. CONTACT: Michelle Hemingway, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/336-5061.

Oct. 12-15 **Thoracic Organ Transplantation** Minneapolis Heart Institute Foundation; Westin La Paloma, Tucson, AZ. CONTACT: Don Young, 2810 57th Avenue North, Minneapolis, MN 55430; 612/574-7982.

Oct. 13-15 **Annual Orthopedic and Trauma Seminar** Hennepin County Medical Center/Hennepin Faculty Associates Office of Academic Affairs and University of Minnesota; Pillsbury Auditorium, HCMC. CONTACT: Laura Carroll in Orthopedics, Hennepin County Medical Center, 612/347-2075, Ext. 3736.

Oct. 13-15 **Nineteenth Annual Fall Continuing Education Seminar** Minnesota Academy of Physician Assistants; Best Western Apache, Rochester, MN. CONTACT: Sonja L. Heiniger, 11794 Akron Avenue East, Inver Grove Heights, MN 55077; 612/552-8876.

Oct. 14-15 **Cutaneous Laser Surgery** HealthSpan; Abbott Northwestern Hospital, Minneapolis, MN. CONTACT: Don Young, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

Oct. 15 **Managing Cancer Pain: Knowing Is Not Enough** HealthSpan; Lutheran Brotherhood Conference Center, Minneapolis, MN. CONTACT: Annette Carlson, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7910.

Oct. 15-16 **International Symposium on Myeloproliferative Disorders** Mayo Foundation; Siebens Medical Education Building, Rochester, MN. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 507/284-2509.

Oct. 16 **Problem Solving in Hypertension** Mayo Foundation; Mayo Foundation, Rochester, MN. CONTACT: Registrar, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Oct. 21 **Third Annual Conference for CME Planners** Minnesota Medical Association; Northland Inn, Brooklyn Park, MN. CONTACT: Jane Phillip, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875 or 800/999-1875.

Oct. 23-27 **Advances in Diagnostic Radiology** Mayo Foundation; Sea Island, GA. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Oct. 24-25 **Advanced Trauma Life Support (ATLS)** HealthSpan; United and Children's Hospital Conference Center, St. Paul, MN. CONTACT: Annette Carlson, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7910.

Oct. 27-28 **Trauma Management for Primary Care Providers** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Office of CME, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Oct. 28 **ECG Conference** Hennepin County Medical Center/Hennepin Faculty Associates Office of Academic Affairs and University of Minnesota; Mall of America Grand Hotel, Bloomington, MN. CONTACT: Ann Samways, CME Coordinator, 612/347-2078; or Robin Hoppenrath, Manager, Office of Academic Affairs, 612/337-7128.

Oct. 28-29 **New Ulm Fall Seminar** HealthSpan; Holiday Inn, New Ulm, MN. CONTACT: Don Young, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

Oct. 29 **Update and Case Reviews in Otorhinolaryngology—Head & Neck Surgery** Mayo Foundation; Mayo Foundation, Rochester, MN. CONTACT: Registrar, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

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Mankato Clinic, Ltd. is seeking additional BC/BE physicians in the following specialties: orthopedics, radiology, invasive cardiology, oncology/hematology, family practice, and general internal medicine. The Mankato Clinic is a 59-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. M. P. Wheeler, President, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (10/93-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

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Forest Lake Doctor's Clinic is seeking a BC/BE family physician and ob/gyn to join a growing 12-physician multispecialty practice. Located 25 miles north of Twin Cities in progressive community with excellent schools, outstanding recreational activities. Hospital located across street from clinic. Respond with CV or call Doug Sill, M.D., Harvey Frank, M.D., or Geoff LaGary, Administrator, 121 SE 11th Avenue, Forest Lake, MN 55025; 612/464-7100. (11/92-R)

Olmsted Medical Group is seeking BC/BE physicians in the following specialties: emergency medicine and ob/gyn. Great opportunity for well-trained physicians to join a 70-physician multispecialty group in a dynamic, progressive practice. In addition to the main office in Rochester, the group operates eight branch offices in southeastern Minnesota. Excellent salary/benefits package includes malpractice insurance, flexible benefits plan, 401(k) and profit sharing, and relocation assistance. Send CV to Olmsted Medical Group, Attn: Susan Schuett, 210 Ninth Street SE, Rochester, MN 55904. (1/92-R)

Internal Medicine and Dermatology practice opportunities available at the Faribault Clinic. The Faribault Clinic is a multispecialty group practice of 18 physicians. Faribault is located 50 miles south of Minneapolis on I-35. For more information contact Ray W. Wood, M.D., or Ken Smith, Administrator, 924 NE First Street, Faribault, MN 55021; 507/334-3921. (4/94-R)

Stillwater: 20-physician multispecialty group with emphasis on primary care seeking BC/BE family physician. Scenic location with excellent school system, supportive medical community with strong local hospital, competitive salary and benefits. Send CV to Jon Pedersen, St. Croix Valley Clinic, 921 South Greeley, Stillwater, MN 55082; 612/439-2215. (9/93-R)

Family Physician wanted to join six-physician, three-P.A., two-site family practice group in St. Anthony and Shoreview. Obstetrics available. Competitive salary, benefits package, and call schedule. Contact Gerald Pitzl, M.D., Silver Lake Clinic PA, 612/788-9251. (7/91-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

GENERAL SURGEON BC/BE

The Department of Surgery at the Mayo Clinic in conjunction with the Decorah Clinic is seeking a broad-based general surgeon to join the Mayo Regional Facility in Decorah, Iowa, 70 miles south of Rochester, Minnesota.

This position offers an excellent opportunity to establish a surgical practice in an established 9-person, Mayo-affiliated medical clinic in this town of about 8,100 with a 60-bed hospital and a county population of 26,000.

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Michael G. Sarr, M.D.
Department of Surgery
Mayo Clinic
Rochester, MN 55905

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Family Practice, Surgeon: Five family practice group seeks surgeon, plus one or two family practice physicians. Population 8,000. One hour south of Burnsville Center. Lakes, industry, negotiable salary. Clinic adjacent to hospital. Ample free time to enjoy family life. Contact James W. Dey, M.D., or Ruth Hawker, Clinic Manager, 501 North State Street, Waseca, MN 56093; 507/835-3110. (9/93-R)

Mora, Minnesota: Aggressive, young, seven-physician family practice group seeks to add one or two physicians. Mora is a friendly community located one hour north of Minneapolis/St. Paul. There is abundant outdoor recreation in the area, including Mille Lacs Lake. The town is host to the Vasaloppet Ski Race, a half-marathon, canoe race, and bike race. If you are interested in this practice opportunity, and you should be, please contact Peter J. Donner, M.D., Mora Medical Center, Ltd., Mora, MN 55051; 612/679-1318 (wk); 612/679-1981 (hm). (11/92-R)

Urgent Care Physicians: Immediate part/full-time positions available at two Convenience Care centers in northwest suburbs of the Twin Cities. Family practice trained providers sought. Excellent opportunity for those physicians seeking freedom from call and hospital responsibilities. Patient base is primarily young adults and children. Attractive hours and compensation. Send inquiries to Robert Kantor, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

ALEXANDRIA CLINIC, P. A.

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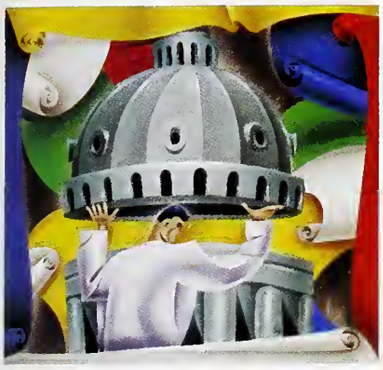

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Following the Paperless Trail

I enjoyed your August issue on computers in the office. We have been using the same software as the Harvard Community Health Plan in our office for six years in a paperless (chartless) mode with great success. We have all of our records stored on computer (more than 20,000 patients) and have retired our paper charts except those of people under 25, which we keep available for access to their immunizations records. We are a three-doctor group with two nurse practitioners serving 100 to 150 patients per day. The only paper records we keep are EKGs and original letters from consultants. These are abstracted into the computer but kept for legal reasons. We also store records of phone calls, ER visits, nursing home visits, and inpatient encounters. Lab test results done at the hospital (where most of our lab work is done) are transferred from computer to computer. Our long-range plans are to install terminals in the exam rooms and to scan those paper documents we still maintain for faster access.

A recent episode demonstrates the advantage of these records. Last week I received a call at 4 a.m. from the ER doctor about a patient who had severe priapism from injecting too much medication to treat his impotence. The ER physician did not know what to do but did know that the patient had been treated in the office for a similar episode a few weeks earlier. I was able to walk into my study, turn on my lap-top computer, dial into our office system, read the treatment to the ER physician, and return to bed in about 10 minutes!

The ability to recall these records from multiple places and to have several persons using the record at the same time has great advantages. And we never have misplaced records. The computer-generated summary allows us to quickly review all active problems and medications at the time of an office visit.

It is much easier for small groups like ours to install and maintain such systems. For $15,000 we can have a complete paperless system, while big groups like Mayo and the metropolitan HMOs face enormous investments. Even Harvard is struggling to implement the system it created 30 years ago. It is fun to know that outstate practitioners can be on the leading edge of technology! Thanks again for the articles.

William E. Davis, M.D.
Family Medicine of Winona, P.A.
Winona, Minnesota

A Closer Look at Drug Promotion

Ralph C. Heussner's article, "Peddling Drugs to Docs" (*Minnesota Medicine*, June 1994) was of special interest to me. I certainly share his thoughts and comments on pharmaceutical advertising. However, he seemed to focus on the pharmaceutical representative in his discussion, but I wonder if pharmaceutical advertising in the form of journal ads and first- and third-class mailings shouldn't be scrutinized just as closely. It seems to me that every day I receive a new journal that comes without any solicitation from me. They are usually attractive and the articles are often meritorious, but they are chock-full of very glamorous advertising. My mail usually includes some first-class letter that I open and then am annoyed to find that it is from the drug rep I saw last week, who's trying to get another crack at my attention. The third-class mail nearly always goes directly from my desk into the wastebasket, unopened.

It is my contention that the medical profession probably has more journals than it has physicians with the time or inclination to read them. I would be surprised if the first- and third-class mailings are effective or if the pharmaceutical industry even believes they are. My guess is that they take the philosophy that money put into marketing purposes might possibly serve them some financial gain, but paying more corporate taxes or lowering the price of their products will not. In addition to these concerns, I also have bad feelings about all the paper, magazines, and sample containers that require hauling away to the landfill.

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Single-Payer Persistence

Charles R. Meyer, M.D.

▲ September 1945: President Harry S. Truman proposes a national health program.

▲ September 1993: A proposal calling for further study of the single-payer system is narrowly defeated by the House of Delegates of the Minnesota Medical Association.

▲ January 1994: A petition drive in California bids to put a single-payer referendum on the November ballot.

Why doesn't it go away? Is it because it's simple sounding? Egalitarian? Sensible? Whether dubbed national health insurance, single payer, or, by its vocal critics, socialized medicine, single, centralized government payment for all medical care is reminiscent of Wile E. Coyote in the "Road Runner" cartoon; no matter how high the cliff he falls from or how big the blast he withstands, he keeps coming back, ready for yet another battle.

In this issue, we present three perspectives on the single-payer system. Glenn Pearson, M.D., says single payer would work for the American people and for doctors. Sen. Paul Wellstone echoes this view and describes the single-payer bill he introduced in Congress. Sen. Dave Durenberger responds that managed competition, not single payer, is the answer to the health care mess.

Why hasn't the single-payer proposal gone the way of misguided concepts like evil humors and leeches? As Pearson and Wellstone note, it does address valid flaws in our current system—the uninsured, inaccessible care, escalating costs, dysfunctional incentives leading to technology metastasis and "do more" philosophy, and growth of administrative costs. The single-payer solution has apparent simplicity, good intentions, and many allegedly successful templates from other countries. In their book, "The National Health Program Book," Physicians for a National Health Program founders Himmelstein and Woolhandler present six essentials of their proposed program: universal comprehensive coverage; no out-of-pocket payments; "lump-sum" operating budgets for hospitals; separate capital budgets; a single, public payer; and public accountability but minimal bureaucracy. So who wouldn't want that neat package?

"Why hasn't the single-payer proposal gone the way of misguided concepts like evil humors and leeches?"

Perhaps the question about single payer more pertinent than why hasn't it gone away is why haven't the American people bought it in 50 years? I offer the following reasons: 1) Cost—Adding covered individuals and erecting bureaucracy will add costs. Methods of cost savings under a single-payer system, such as eliminating administrative costs of insurance and using central planning to rationalize the expansion and delivery of technology, are either untested hypotheses or a return to previously failed techniques. Also, the proposed cost-containment method is budget limits, a strategy that has yet to answer the question: What happens after we say we won't pay for it? 2) The Big Brother specter—Americans distrust government and the people who run it. Show Americans a politician or a bureaucrat and ask them if they would buy a health care plan from this person. They might, but they would expect it to have the efficiency of the post office, the paperlessness of the military, and the compassion of the IRS. 3) Weak analogies—The Canadian comparison fails on many counts. Despite its geographic proximity, Canada is a different culture with different expectations and paltry sociological problems compared with the United States. The difference in expectations can be summarized by considering how far Americans are willing to drive to get a mammogram or an MRI. Furthermore, the economic success story of the Canadian system seems to have dimmed in the last year, with provincial deficits leading to health care belt-tightening.

Ultimately, when you cut through the complexities of budget limits, cost savings, and equal access, whether you favor the single-payer plan boils down to whether you think the government can run such a system effectively. Hawkers of the single-payer system will have to overcome such American cynicism as that voiced by Elbert Hubbard when he labeled government "legalized pillage."

As I write this, Congress is painfully lurching toward some action on health care reform this year. It likely will not be a single-payer system. But I predict the coyote will be back. MM

Bullish on Physician Opportunity

Incoming MMA President Andrew J. K. Smith encourages physicians to take the reins of health system reform.

BY FRAN MILLER TOUBIN

Texas native Dr. Andrew J. K. Smith has lost his accent in the 22 years he's lived in the land of 10,000 lakes. What he hasn't lost is his frontier spirit, at least when it comes to health care. With an optimism not widely shared by his peers, Smith believes Minnesota is still a land of opportunity for physicians—if they take the lead in reforming the health care system.

As he assumes the presidency of the Minnesota Medical Association this month, Smith says he has many goals and aspirations for his term. If he can accomplish just one thing, however, he says it will be to help physicians across the state get beyond the turmoil, anxiety, and negative feelings they've experienced in the last two or three years and concentrate on the opportunities—of which Smith believes there are many—to take control of their future by restructuring medicine and developing physician-directed organizations.

Smith believes fervently that this can be done while preserving high-quality health care if physicians continue to focus on maintaining professionalism—that is, putting patients' interests above all others.

"As we begin to look at the design and development of new systems of health care delivery, and we do that in a patient-oriented fashion," says Smith, "we'll find that many of those efficiencies actually allow us to provide better health care. What we're talking about are such things as improved ways that doctors can communicate with each other about patient care."

Smith's statements are not based on wishful thinking, but personal knowledge and experience. For the past several years, he has been among a small group of Twin Cities physicians putting together a new kind of physician-owned and directed health care delivery system known as clinics without walls. As board chair of Criterion HealthCare Network, Smith has been involved in gathering and assimilating information that will facilitate this experimental structure, which links physicians' offices electronically and enables practitioners in different groups and hospitals to share information and costs in the same way that larger organizations do (see Face to Face, *Minnesota Medicine*, November 1993). Smith's own five-member practice in Plymouth is part of the network.

"I think there's no question that these new physician-directed organizations can prosper if they are designed properly, are based on patient interests, and have the kinds of information systems that allow costs to be controlled and quality to be maintained," says Smith, who emphasizes that the MMA was instrumental in

"I can envision a system that may be very different, but in many ways would be much more efficient and would allow physicians to get back to basics."

developing a conceptual framework for the design of clinics without walls. He believes the association can be a valuable resource for physicians who want to develop similar organizations, and says as president, he will strive to educate members on the ways in which the MMA can meet their own needs. For example, he says, the MMA offers seminars throughout the state that deal with the kinds of legal and legislative concerns physicians and their practices are facing.

Despite his underlying optimism, however, Smith is quick to point out that the success of Criterion and other similar physician-directed networks is predicated on the ability of physicians to set aside their own individual interests. "They'll either do that or it will be done for them," predicts Smith, "because the forces out there are bigger than any individual physician or group of physicians."

Physicians can help mold a new health care delivery system, says Smith, because they are now considered part of the solution—rather than an obstacle—to health care reform. Citing the evolution of MinnesotaCare as an example, he explains that the MMA has played an active role on committees and panels in helping design a reform plan that will ensure health care access to Minnesota residents.

According to Smith, largely as a result of much physician input and the Legislature's subsequent reliance on physician knowledge and expertise, MinnesotaCare is evolving into a system with greater flexibility and more opportunity for the development of physician-directed organizations.

Smith maintains that despite media coverage describing an erosion of public confidence in the profession, he's found that the public continues to respect and trust physicians and expects them to take leadership roles in health care reform. "Physicians need to take advantage of the trust they have with the public and use their power and ability to get down to the business of building systems that are patient-oriented," he says.

"I think physicians are in the best position to balance quality and cost, to do appropriate resource allocation, and to put patient needs first, all of which are necessary to compete in this evolving marketplace. I want to help physicians see that they have alternatives, that they can be the ones managing the managed care, but it's going to take time, effort, and contribution of capital in some instances to make these organizations work."

Coming from Smith, whose knowledge of and involvement in state and national association, professional society, and hospital affairs is broad and varied, this is not mere rhetoric. A practicing neurosurgeon in the Twin Cities since he completed his residency at the University of Minnesota in 1977, the 52-

SMITH continued on page 46

Small Sacrifices

Medical training leaves little room for being a mom.

By Carol L. Joseph, M.D.

They are young and eager. A little anxious at being confronted with a *real* patient, performing their first *real* physical examination. Their white coats shine as they plumb the mysteries of stethoscopes, otoscopes, and sphygmomanometers.

One of the joys of being a doctor is teaching these students the art of medicine. My favorite assignment is helping the second-year medical students learn to interview and examine patients. It is also one of the few chances I have to hear about medical education from the students' point of view.

My last two students seemed much like the others, two young women, bright, hard-working. A casual conversation established that, like myself, one of them had a young child.

"What do you do for child care?" I asked. A difficult problem, we agreed. So difficult, in fact, my young student confessed that during her first year she had sent her 1-year-old child hundreds of miles away to live with her mother.

I was shocked.

"That must have been hard," I said, hiding my feelings. "Yes," she said. "He's back with me now, he calls me Mommy—but he goes with anyone, as though I am nobody special."

I remembered how I had felt when my own daughter was 16 months old and I left her for the first time. I had been chosen to attend a national training session. It was important for my career. It seemed as if I were gone for an eternity; I missed Sarah desperately. When I returned, my husband was at the airport. He had dressed Sarah in a frilly pink sunsuit. I took her in my arms. She went limp. Her eyes, looking into mine, were vacant. She let me carry her for a while, then reached out to go to her father. And for another eternity, it seemed, she would sit on anyone's lap but mine.

ILLUSTRATION BY MICHAEL MAY

This was not the first time a female physician had told me she had sent her child away to a distant relative in order to complete some portion of training. The first time I had heard of this, I thought it was just an aberration. How could she do it, I wondered. She must not feel the way I do. Perhaps she lacks some maternal instinct. Maybe she just didn't bond. But confronted with this second instance, I raged inwardly against a system that pretends to teach humanism while destroying humanity.

"Can our medical schools make no concessions to the next generation?" I asked.

Then I remembered my own first year in medical school. The acceptance letter and the positive pregnancy test came one right after the other. There was never a doubt in my mind as to what I would do. And never a twinge of conscience. Until now.

Once again, I have the opportunity to attend a national meeting. It will be held on my daughter's fifth birthday. MM

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Balancing Family & Career

Medicine will take all you can give; is there anything left for you?

By Barbara A. Elliott, Ph.D.

Achieving a sense of balance in our lives while having both a career in medicine and a family requires considerable effort. This "balance" is only achieved when several different dimensions of our lives are in sync: our career goals, financial responsibilities, family needs, and personal philosophies. Unfortunately, ambitious and capable people rarely reach such equilibrium. Instead, our desires to "do it all" usually generate a great deal of tension between the time demands of our careers and these other aspects of our lives.

Medicine has been described as a "green-eyed monster" that pervades our lives and possesses our time and energy when we let it. But it also meets our needs to feel helpful and adequate. It provides identity and gives us values.

The hard part comes when—as many of us thought before medical school—we realize that there is more to life than "just being a doctor." That often happens when we fall in love, choose a life partner, and establish a family. Then we discover we must be available to more than patients, colleagues, and journals. We may find ourselves stealing away at lunch or in the evenings to spend time with loved ones. But we say that we are "stealing" time, which clearly implies that medicine is still the priority!

Finding our own balance is based on exactly that: clarifying the priorities in our lives. Practically, this means defining how we budget our time and energy. Personally, it means listening to both our hearts and our heads as we try to decipher what is most important to us.

Getting a sense of self is not easy to do. It is not easy because medical school trained and conditioned us not to do it. Some of the strongest lessons from medical training have to do with learning that there is never enough time, that personal needs and desires need to be put after everyone else's, and that no matter how hard we try, there is always more to do and learn in medicine. Medical training taught us to put our own concerns last and to allow the study and practice of medicine to take precedence over all else.

These lessons won't lead to achieving a comfortable routine. Instead, we have to look inward. When we look closely, some of us learn that our career goals are most important to us. Some of us have financial needs and responsibilities that take priority. Still others find that our families always come first. Personal philosophies help us establish our own unique balance among these different aspects of our lives.

Each of us has our own needs and values that make one lifestyle or work arrangement better than another. But we can only find a solution when we know what we want. Then it can be negotiated. Even then, what we discover about ourselves and arrange at one time is likely to be only a temporary solution. We change; our needs change. We marry or get divorced. We pay off our debts. The people we share our lives with change, too. Our spouses get jobs. Our children grow up. Work colleagues come and go. We find it is time to reassess our priorities and redesign our lives and practices.

Defining what we want and negotiating to get it are first steps in structuring balanced lives. The actual day-to-day behaviors that create a comfortable routine are the next part of the challenge. How can we resolve conflicts at work and at home? How do we say no and not feel guilty? How do we respond when we are discriminated against because of our choices?

These issues will be discussed from 4:30 p.m. to 6 p.m., Thursday, September 29, at the MMA Annual Meeting in St. Cloud as part of the Committee on Women Physicians session, "Balancing Personal and Professional Life." Men and women physicians are invited to attend the session, which will be an opportunity to learn from one another. Indeed, knowing we are not alone as we face these challenges allows us to model healthy, balanced living for our patients and our families. And it keeps us sane. MM

Barbara Elliott teaches in the School of Medicine at the University of Minnesota, Duluth.

ILLUSTRATION BY JOHN BERRY

Pulling for Reform

States like Minnesota are striving for health reform, but the battles are getting tougher.

Allan Baumgarten

All health care is local, as Tip O'Neill would have said. The late speaker of the U.S. House of Representatives would have been pleased by the vigor with which many states have tried to solve the health care riddle of our time: how can we expand access to health care while containing its cost and improving its quality? States such as Minnesota have volunteered to be the testing ground for a variety of health reform initiatives.

These states, however, have already discovered that their most creative ideas often run into a variety of obstacles:

• Federal laws and policies limit states' abilities to take certain approaches. In addition, many state leaders are reluctant to launch state initiatives when far-reaching federal action may be forthcoming.

• Marketplace activity in some places is already outpacing state legislative initiatives.

• Maintaining the political consensus needed to enact reform becomes more difficult as issues get more specific and choices get tougher.

Federal Issues

A common theme of state reform initiatives is making health insurance more affordable by bringing as many people as possible into a "public pool" where premiums are community rated, or at least where insurers' latitude to set prices and accept or reject applicants because of their medical history is severely limited.

The problem is that most people are not in the public commercially insured pool today, but, rather, are in other risk pools. For example, a growing number of Minnesotans, now about 1.2 million, are in managed care self-funded arrangements, in which the employer assumes the cost of medical care rather than paying a premium to an insurer or health maintenance organization (HMO) to accept that risk. Much of this growth is coming from employer groups who had previously been in insured HMO plans. Under the federal law known as ERISA (the Employee Retirement Income Security Act), states generally may not regulate self-funded health benefit plans. (See sidebar, page 12.)

States like Washington, whose 1993 health reform law mandates that employers provide health coverage, have constructed systems that depend on getting congressional waivers from ERISA. However, both big business and big labor agree on the importance of not changing ERISA. With such a potent coalition opposing state requests, waivers are unlikely, and Washington faces having to redesign its reform plan and probably limit the plan's scope.

Minnesota legislators tried to avoid similar ERISA entanglements and did not impose an employer mandate. However, the 2 percent provider tax enacted in 1992 to help finance MinnesotaCare was challenged on ERISA grounds. The state won at the district court level earlier this year. However, that decision is subject to appeal, and circuit courts of appeal in other parts of the country have reached opposite conclusions about whether ERISA preempts imposing surcharges on self-funded plans.

In addition, a significant portion of the U.S. population is in the Medicare program and the state-federal Medicaid program. The federal government controls these programs, so their enrollees are effectively out of the state's reach. Similarly, federal employees and households covered through the armed forces are also beyond the reach of state reform.

While only Congress can grant ERISA waivers, executive branch agencies can allow states new flexibility with these programs. This summer, Minnesota is submitting a far-reaching waiver request (known to some as the "cosmic" waiver) to the federal Health Care Financing Administration (HCFA) that would enable the state to bring Medicaid and Medicare enrollees into the public pool. In essence, the state is assuring HCFA that Minnesota's limits on annual expenditure increases will work for Medicaid and Medicare and requesting that the state get the flexibility it needs to add those enrollees to the public pool.

Legislators also face uncertainty about what version of health reform, if any, will be enacted by the U.S. Congress in 1994 and how that will affect state initiatives. Much of what is contained in President Clinton's proposals or the bills approved by the House and Senate committees is consistent with Minnesota's approach to reform. Yet, under some of the scenarios now under consideration, Minnesota would likely see tax dollars leaving the state to help subsidize coverage in other states where more people are uninsured. That might be seen as a reasonable price to pay for achieving universal coverage in states with poorer economies than Minnesota's. Perhaps more troubling is that dollars from Minnesota will be needed to maintain the level of payments to less efficient providers in states where Medicare payment rates are much higher.

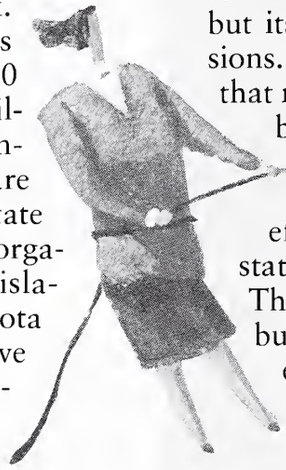
Marketplace Activities

States have also found that marketplace activity is already outpacing state legislative initiatives. Minnesota's approach to reform is part regulation and part marketplace competition. The competition element is a vision of vigorously competing integrated service networks (ISNs), a new generation of managed care organization that brings together physician and hospital services with health plan administration.

This past fall and winter, health plans and providers in Minnesota were in a frantic race to form integrated networks through joint ventures, mergers, and other configurations. For the first time in Minnesota, HMOs merged with hospitals. The HealthPartners HMOs

merged with the St. Paul-Ramsey Medical Center and the Ramsey Clinic physicians' group. The Medica HMO and HealthSpan hospital system merged to form Allina. Blue Cross and Blue Shield of Minnesota, the largest health plan company in the state, entered into a series of joint ventures with physicians groups and physician-hospital organizations in several parts of the state.

In effect, these organizations and others used the current body of state HMO regulation to create integrated systems without waiting for the state to prescribe how ISNs should look. Now that the dust has settled, more than 80 percent of the 3.2 million Minnesotans enrolled in managed care organizations in the state are now in just three organizations. Some legislators—and the Minnesota attorney general—have questioned whether integrated systems have gone too far, leaving the state with an uncompetitive market dominated by three organizations.



The pace of mergers and joint ventures has dropped off somewhat for several reasons. First, as recommended by the commissioner of health, the Legislature has slowed the schedule for starting ISNs, so that the new system will not be fully implemented until July 1997. Why slow down the transition period? According to Health Commissioner Mary Jo O'Brien, extending the implementation period was necessary to give purchasers an opportunity to understand how their choices in the market would change.

The ERISA Struggle

THE SCENE IS RE-ENACTED NUMEROUS times each year in state capitols across the United States. Legislators propose brilliant ideas for expanding access to health care or financing that access. They turn to their lawyers sitting at the end of the table, who say, "Sorry, but you can't do that."

"Why not?"

"ERISA."

End of discussion.

The Employee Retirement Income Security Act of 1974 is a federal law regulating employment-related benefit plans. Congress adopted ERISA largely to address abuses with pension plans, but its impact goes well beyond pensions. It was broadly written to ensure that regulation of benefit plans would be uniform and not vary by state. ERISA preempts state regulation of employee benefit plans, though it reserves the states' power to regulate insurance. The distinction is not always clear, but it generally means that employers that self-fund their health benefit plans will not be subject to a variety of state regulations. Courts have held that states may not require self-funded plans to conform to state-mandated benefits or contribute to a risk pool like the Minnesota Comprehensive Health Association.

For purposes of the national and local debates on health reform, ERISA poses a significant obstacle to many state initiatives. Curt Johnson, Gov. Carlson's chief of staff, recently described ERISA as "the brick in the middle of the room you trip on when crossing in the dark." Its supporters would say that ERISA ensures uniformity in regulation of benefit plans and makes it practical for national employers to provide benefits to their employees across the country. —A.B.

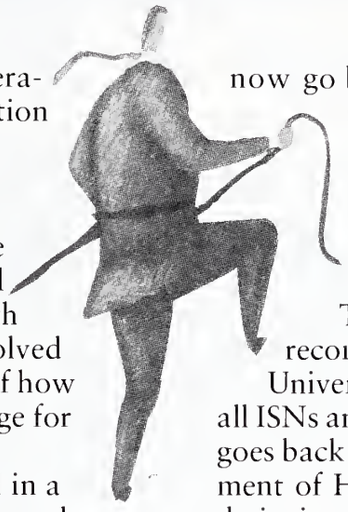
In addition, the health care organizations themselves have found that digesting last year's round of mergers requires an enormous amount of effort. Conducting due diligence reviews, redrawing the organization charts, and trying to blend distinct corporate cultures leave little time for exploring new arrangements or for discussing contracting arrangements with the new physician networks that have emerged in the past year.

The Legislature sought to give a competitive leg up to new managed care organizations that would be community based. The MinnesotaCare Act of 1994 authorized creation of two new models of managed care organizations: the community ISN (CISN) and the cooperative. In creating these new models while delaying licensing of ISNs, the Legislature hoped to give small, rural networks some additional time to form, so that they might better compete with the large, Twin Cities-based health plans.

CISNs are really HMOs that are intended to start and stay small (no more than 50,000 enrollees) and are locally governed. With a few minor exceptions (additional enrollee cost-sharing, fewer reporting requirements, etc.), they are subject to the same regulations as current HMOs. As originally proposed, CISNs were to be transitional and would become full ISNs or disappear in 1997. However, the final version of the act does not sunset CISNs, so they apparently can continue after 1997.

The Legislature also authorized the creation of health care cooperatives, based on the model of rural agricultural cooperatives. These could be risk-bearing insurance entities governed

by their policyholders, or provider cooperatives that are willing to accept capitation contracts.



Political Consensus

Finally, the question remains whether state leaders can sustain the base of political support that is necessary to continue health reform. In Florida, the consensus dissolved when the Legislature faced the question of how much it was prepared to subsidize coverage for the uninsured.

The 1992 MinnesotaCare law passed in a remarkable display of bipartisan consensus and cooperation by the governor and the Legislature. That consensus held in 1993, but eroded badly during the 1994 session, when legislative leaders accused each other of abandoning the principles of reform, and the bills passed by much narrower margins than in previous years.

Not only did the 1994 MinnesotaCare bill slow the pace of reform, in the view of some disappointed parties, it also undermined some of the building blocks of the reform. HMO lobbyists characterized the session as the most anti-managed care in memory. They pointed to bills that imposed a moratorium on new mergers by major hospitals or health plans or required certain HMOs to open their networks to allied health professionals who were willing to abide by the managed care protocols and fee schedules of those HMOs.

Others, such as Michael Scandrett, director of the Minnesota Health Care Commission, suggested that the 1994 bill was consistent with the state's reforms, but that legislators used the bill to send cautionary messages to managed care companies and others. Legislators wanted to lower barriers to entry for new integrated networks, particularly those based in rural areas, so that they wouldn't be dominated by large, Twin Cities-based organizations. They wanted the HMOs to open up their provider networks somewhat so that allied health professionals could participate in managed care systems and have access to enrollees in managed care plans. Indeed, they crafted a law that is probably incapable of enforcement, thereby giving the HMOs and the allied providers until the next session to hammer out a workable compromise.

In Minnesota, 1995 will be the year for key health reform decisions. The Legislature adopted the goal of universal coverage by July 1997 and imposed a mandate that all Minnesotans have coverage by that time. The issue of how to finance the needed subsidies and the broader question of how to finance health care in general now go back to the Minnesota Health Care Commission and the Department of Health. They will present the Legislature with their estimates of the price tag and the options for financing. Then, the Legislature must decide if it is prepared to pay the price, or if the state can't afford universal coverage after all.

The Department of Health will also develop recommendations on what should be covered in the Universal Standard Benefit Set, which will be sold by all ISNs and other insurers by July 1997. That issue then goes back to the Legislature for action. Both the Department of Health and the Legislature will be faced with designing a benefits package that is comprehensive enough to meet the demands of advocates for provider groups and others, yet is still affordable.

Some people suggest that the Minnesota Legislature may be too involved in negotiating the implementation details. Other states have tried to limit legislative involvement in crafting the details of their reform. Washington state's 1993 reform law created a five-member Health Services Commission with rule-making authority. That commission will present a uniform benefits package to the Legislature. In a process similar to one Congress now employs for decisions to close military bases, the benefits package will take effect unless the Washington Legislature specifically rejects it during the 1995 session. Furthermore, the next chance to modify the uniform benefits package doesn't come until 1999.

Of course, one reason the Minnesota Legislature stays so involved in the details of health reform is that the current DFL leaders in the Minnesota Legislature are not inclined to yield that responsibility to Republican Gov. Arne Carlson. The September primaries and the November general election could result in major changes in the direction of state health reform and in who is steering the ship. If Arne Carlson does not win re-election, or if the DFL loses control of the House of Representatives, many new faces and ideas will emerge in executive branch agencies, the Minnesota Health Care Commission, and the Legislature.

Justice Brandeis once said that states are the laboratories of democracy. Perhaps the lesson of this year is that states can't run their health reform laboratories themselves and are limited on all sides in what they can accomplish. MM

Allan Baumgarten is a consultant on health care policy, finance, and local market strategies and the author of Minnesota Managed Care Review, *an annual report analyzing key trends and issues in Minnesota's managed care marketplace.*

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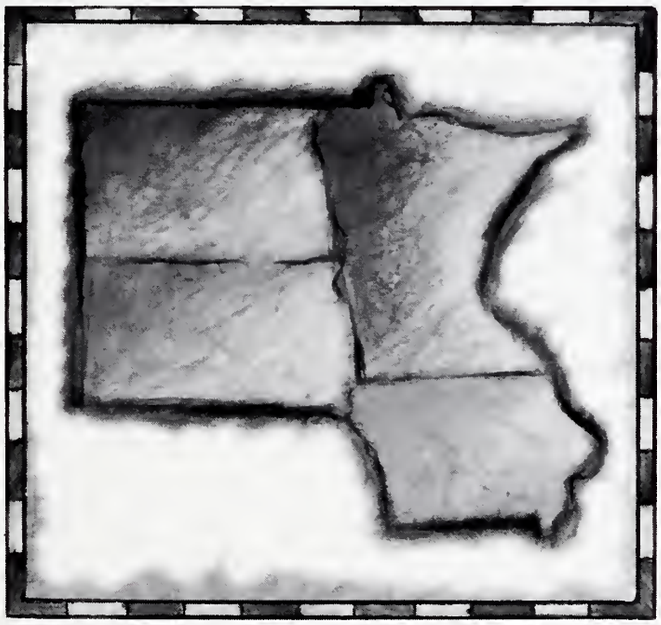

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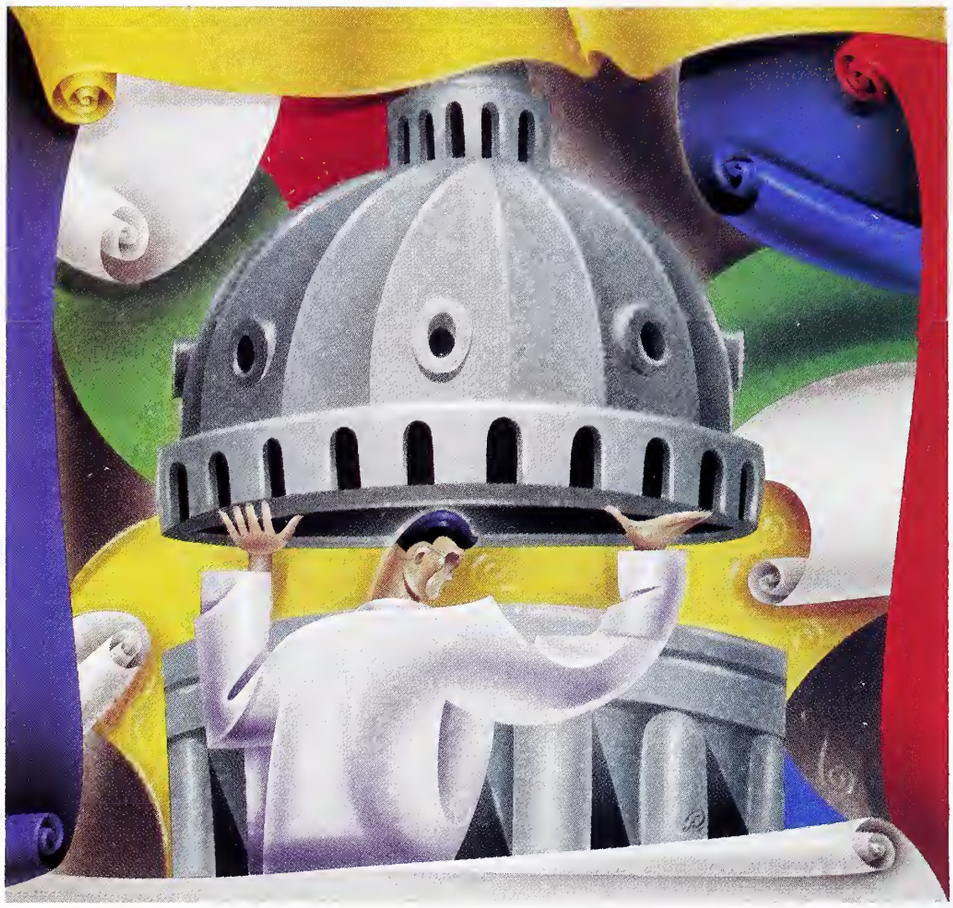

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WHAT EVER HAPPENED TO SINGLE PAYER?

Single payer is not among the major proposals being debated in the halls of Congress or on the Senate floor. But its echo can be heard in corridors across the country as physicians, politicians, business people, and the public at large look for ways to improve the U.S. health care system. This month, Minnesota Medicine *listens up.*

★ ★ ★

The Single-Payer Solution

A Physician's View

Glenn E. Pearson, M.D.

America has some of the best health care in the world—for those who can afford it. But our costly and inefficient health care system leaves millions of Americans with no access. Following is an outline of the reasons we need health system reform, and, specifically, why a single-payer system would be the best type of reform for patients and physicians.

Why Do We Need Reform?

★1. America is the only major Western country that does not provide comprehensive health insurance to all its citizens. We are the richest country in the world, yet 39 million Americans have no health insurance, including more than 12 million children.[1,2] Eighty-four percent of the uninsured are employed workers and their families; even 6 percent of physicians have no insurance. The only groups of Americans universally covered are legislators and judges. Some 50 million Americans have insurance with coverage so inadequate that it would leave them bankrupt in the event of a major illness.[3,4]

★2. Rationing of health care is much worse in the United States than in Canada, Japan, and Europe.[1,5-9] More than 14 million young women in our country are not covered for maternity care; as a result, 25 percent of American women do not receive adequate prenatal care—the worst rate in the developed world. Forty percent of children in America aged 1 to 4 do not have their full series of vaccinations—again, the worst rate in the developed world.[1,8]

We also ration care to adults. Lacking insurance, millions of Americans fail to receive needed preventive services, such as blood pressure checks, Pap smears, breast exams, and eye exams.[10] Thirty-six percent of Americans report avoiding care because of cost,[11] and numerous studies show increased morbidity and mortality for those delaying needed health care. (Delayed care is tragic for those persons, and costly because it leads to more expensive tertiary interventions.)[12-15] When compared with Canadians, 10 times as many Americans report financial barriers to needed health care and twice as many report non-financial barriers.[16]

★3. America has the most inefficient health care system in the world.[5,17-19] About 300,000 hospital beds, one-third of the U.S. total, are empty, while there are shortages of beds in some of our largest cities and in rural areas.[1,16,20] We have too many specialists (more than 70 percent of U.S. physicians are specialists; whereas more than half of Canadian physicians are in primary care).[2] We have excesses in technology. For example, there are 10,000 mammography machines in the United States, although 2,000 could meet all current demand. Because machines are under-utilized, cost per test is twice as high as necessary, and quality suffers when mammographers perform too few tests to maintain their competence.[1,21,22]

★4. America has the most costly health care system in the world. In 1993, U.S. health care costs totaled over $900 billion, representing 14.4 percent of our gross national product. Other Western countries spent only 8 percent to 10 percent of their GNP on health care.[1,5,23]

★5. America ranks at or near the bottom of the Western world on every measurable health statistic.[5,18] America is 16th in the world in life expectancy and 22nd in infant mortality. Even some developing nations, such as Singapore, have substantially lower rates of infant death than we do. Our health statistics for ethnic minorities fall further yet when compared with most Western countries.[1]

★6. Our inefficient health care system is costly for U.S. businesses, decreasing their competitiveness in the world market.[24,25] Chrysler Corp. spends $5,300 on health costs per employee per year in the United States; Chrysler in Canada spends only $1,700. In 1991, General Motors spent $3.2 billion on health care for its employees—more than it spent on steel. Many other U.S. industries show similar problems related to health costs.[1] Our current system also creates incentives for Americans to remain unemployed: staying on Medicaid is often more attractive than finding employment and losing health insurance. In fact, inability to pay medical bills is the leading cause of personal bankruptcy

in the United States.[2]

★7. The United States is the only major Western country to rely on competition to improve health care quality and costs. The United States has encouraged free-market competition to improve our health care. We have specifically avoided health planning, budgets, and controls on prices and technology. We have by far the most HMOs, and we have let them compete with each other and the fee-for-service sector in hopes of improving efficiency, quality, and cost in health care.[26-28]

Canada, Japan, and all of Europe have taken a completely different approach to their health care systems in the past 20 years. All rely on health planning with global budgets, hospital budgets, separate control of capital spending, and some controls over fees and prices.[1,5,18] Reliance on competition is viewed as a curious American obsession.

Thus, for more than 20 years, we have been participating in a huge unintended health care experiment comparing the United States' "competitive" health care system with the rest of the Western world's reliance on health planning and budgets. The result has been very clear: Canada, Japan, and all of Europe have excellent health care for all their citizens for 40 percent less cost than in the United States. America's free-market approach has created the most costly and inefficient health system in the world, while leaving tens of millions of our citizens without health insurance.

Why Is Single Payer the Best Choice?

★1. A single-payer type of health care system would address all of the above problems. From day one, we would have universal, comprehensive insurance coverage, eliminating financial barriers to access and saving billions of dollars each year because Americans would get needed health care much sooner.[2,29,30]

★2. Instead of billing for each individual patient, hospitals would be funded by global operating budgets, virtually eliminating their need for billing departments (saving $30 billion per year).[29,31] Also, hospitals and HMOs would have separate capital and operating budgets, which would prevent them from diverting health care dollars for extra profits or unneeded expansion. This would significantly decrease both excessive intervention (under fee-for-service) and skimping on care (under DRG-type prospective payment), since neither inflating revenues nor limiting care could result in financial gain to them.

★3. A single public payer similar to Canada's (which uses 0.7 percent of revenues for overhead) would administer the insurance portion of the health system, replacing the 1,200 private insurers now in the United States (with 13 percent overhead costs). This would markedly improve efficiency, saving another $30 billion each year.[1,18] Also, since a single insurance entity would represent all 280 million Americans, patients would have much more bargaining clout on fees and prices than they do now, resulting in even more savings. (Notably, Americans currently pay 60 percent more than Canadians for prescription drugs.)[1,19]

★4. Single payer would also markedly reduce billing and office expenses for physicians. All medically necessary care would be covered; one simple billing form would be used, there would be no copays to bill for, virtually no utilization review bureaucracy, and no preauthorization screening. Physicians could spend more time where they belong—taking care of patients. Single payer allows practice patterns to be monitored, leading to simpler, more effective public accountability. More detailed review would be reserved for physicians displaying outlandish practice patterns. The average physician's office overhead expenses would be reduced by $26,000 per year, and physicians would have much less bureaucratic hassle.[17,18,29]

★5. With single payer, delivery of health care remains private. Ninety-five percent of Canadian physicians are private fee-for-service doctors, a far higher percentage than we currently have in this country.[1] Patients would have the freedom to receive care in whatever setting they choose. Since insurance would not be tied to employment, continuity of care would be markedly improved (each year millions of Americans change doctors, usually because they change jobs or their employer switches insurance).[18,32]

★6. Funding for single payer would come from a modest payroll tax of about 9 percent for large employers (half that for small employers), and 2 percent for employees. These proposed new taxes would replace what U.S. businesses and citizens now pay in insurance premiums, taxes, and copays (large employers now average more than 10 percent of payroll for premiums and taxes for health care[25]). Independent research predicts three-fourths of American families would pay less for health care under single payer than they do now, or less than they would under managed competition.[24,29,33]

★7. Savings with single payer are substantial. Reducing administrative inefficiencies in insurance companies, hospitals, and physician offices would save more than $100 billion per year.[18,29,35,36] With additional savings from better resource allocation, more primary care, and lower prices, single payer would save $65 billion annually in health costs compared with other reform propos-

als, according to one highly respected study.[1,34] A majority of U.S. health economists realize this; in a recent poll, they favored a single-payer system over our present system or managed competition.[1]

★8. Single payer doesn't skimp on care. Compared with Americans, Canadians have substantially more physician visits and medical procedures per capita and significantly fewer delays in care for serious illness.[1,16,22,35] Hospitalization rates, transplant rates, quality of physicians, treatment outcomes, and quantity of medical research are essentially equal in both countries.[1,21,37]

★9. Physicians would fare well under single payer. Physicians in a single-payer system would be free to practice in whatever setting we choose. No longer would we have to worry about whether patients have insurance or whether they can afford needed treatment. Intelligent health planning would be done by consumers and physicians working together at a local level instead of by insurance bureaucrats with profit as their main motive. Patients would be coming in earlier for help. They would be less fearful and less angry about costs and coverage, and, thus, easier to treat. Americans as a whole would get markedly better prenatal care, better care for infants and children, and better preventive care for the poor and middle class. Net payments to U.S. physicians would actually increase by over $9 billion per year (we'd have more patient visits because everyone could afford care, and we'd have lower billing costs).[1,2,38] In addition, we'd have less utilization review and other paperwork hassles.

What Do Americans Think?

A majority of Americans favor a single-payer system. Numerous polls show that a majority of Americans favor a tax-financed single-payer system over our current system or managed competition.[39] A 1990 poll comparing satisfaction with health care in 10 Western nations showed that Americans were least satisfied and Canadians most satisfied.[40] When asked to compare their system to ours, 95 percent of Canadians preferred their own system to ours.[16]

Most physicians want change; many support single-payer. More than 80 percent of U.S. physicians polled are currently unhappy enough that they would accept 10 percent less income in exchange for less paperwork and less utilization review.[1] In reality, Canadian physicians are already without these headaches, and most earn incomes similar to U.S. physicians' incomes. Pediatricians and internists actually net slightly higher incomes in Canada.[41] (No wonder an extensive survey of Canadian physicians in 1992 found that 85 percent prefer Canada's system to ours.) A 1993 survey showed that physicians with an average of 10 years of practice in both Canada and the United States were three times more enthusiastic about the Canadian system.[1] U.S. physician groups representing more than 130,000 physicians are on record supporting single payer.[42]

What About Managed Competition?

Managed competition may be worse than no reform. According to the theory of managed competition, price-conscious consumers will promote competition between HMOs, resulting in controlled costs and improved quality.[43,44] (Sound familiar? See "Why Do We Need Reform?" item 7, page 18.) Most managed competition reform bills include a mandatory minimum insurance benefits package (poor coverage in all proposals but President Clinton's). Employees are responsible for 20 percent to 50 percent of the cost of insurance premiums for the cheapest plan, and they are responsible for the full cost of plans with better coverage plus significant copays (up to $15,000 per year per family in the latest proposal).[45] Employers that provide better coverage to their workers would lose their tax write-off for anything above the cost of the cheapest plan available. The poor are given subsidies to help them afford insurance.[43]

Sadly, the most powerful factors found to improve health care in every other Western country are left out of this type of reform: universal insurance coverage and health planning with budgets. There is ample evidence to suggest that managed competition will not work.[1,5,46,47] The population in half of the United States is too sparse to promote true competition.[48] Numerous studies show managed competition will actually increase administrative costs (for example, the $300 billion spent annually now for Medicaid/Medicare, with 3 percent overhead, will be changed over to private insurance, currently with 13 percent overhead).[1] A few giant insurance corporations will dominate (10 now control 70 percent of the HMOs in the United States) with profit as a bottom line. Additionally, numerous independent studies have already concluded that managed care does not save money or improve quality compared with fee-for-service.[2,17,44,48,49]

MinnesotaCare (Minnesota's form of managed competition) is weak reform. MinnesotaCare already has a projected $250 million deficit by 1997, even though 250,000 Minnesotans are still without health insurance (and there is no credible plan for insuring them). In fact, thousands of children have dropped out of the Children's Health Plan since passage of MinnesotaCare because the copays are too high. Insurance coverage under MinnesotaCare is inadequate (given the plan's $10,000 maximum yearly hospital benefit, a family would be bankrupt

in the event of a major illness). MinnesotaCare also does little to decrease administrative waste in the insurance industry (some sectors are allowed to keep up to 25 percent of premiums for profits and overhead). As a result of MinnesotaCare, three huge insurance corporations now control over 60 percent of covered lives in Minnesota, and they likely will increase their market share in the future. (Will this lead to competition, or collusion?)

What's Blocking Reform?

Special interest groups are blocking effective health reform. Health industry PACs have contributed more than $150 million to congressional campaigns since 1979 and have given millions more to presidential and state office campaigns.[50,51] According to the consumer advocacy group Public Citizen, the health industry will spend more than $100 million in 1994 alone for contributions to and lobbying of Congress, honoraria to media VIPs, and advertising to sway the public.

There is much more to discuss regarding this crucial issue, but, alas, space is limited, so let me leave one last thought with those who remain skeptical: Have you ever heard of anything radical coming out of Canada? Single payer is not radical; it is very practical. MM

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Single Payer

The Best Option for Doctors and Patients

U.S. Sen. Paul Wellstone

Over the last year, I have had countless discussions with physicians about the direction of our health care system and the possibility of single-payer health insurance as a reform alternative. More and more physicians and other caregivers have expressed their concerns about recent changes in the health system and how reform will affect their ability to provide the highest-quality medical care to their patients. Many are concluding that single payer is the best means of reform.

The Risks of Bottom-Line Reform

Many changes in the health system that are supposed to improve the health of the "bottom line" interfere with doctors' clinical decision making, compromise doctor-patient relationships, reduce quality, and increase paperwork and administrative costs. We need to be concerned about a healthy bottom line, but we must be wary of cures that may harm patients and caregivers.

Employers and government programs have increasingly used their market leverage to get discounted prices from providers and to force patients and providers into managed care plans. Some of these discounts squeeze out inefficiencies. But others simply force providers to shift costs to other payers, or discourage practitioners from treating patients whose plans pay less.

Some physicians join managed care plans because changes in their local market have made it impossible to remain independent, but many physicians, especially those in group practice, like being able to devote their energies to practicing medicine instead of to the business side of practice. Many patients enroll in managed care plans because it's the less expensive—or only—alternative, but remain because they get excellent medical care.

With the right incentives, managed care can encourage doctors and other practitioners to coordinate the medical care they provide to patients, improving the quality of care and reducing the fragmentation that many patients now experience. This type of managed care makes the primary care physician the coordinator of diagnosis, treatment, and rehabilitation, while affording appropriate access to specialists.

Some managed care plans, however, simply ratchet down on needed referrals for specialty care. Many doctors have told me that their managed care plans turn the primary care practitioner into a gatekeeper who is responsible for controlling utilization and health plan costs. Even more physicians have described how utilization review personnel, who may have inadequate medical training, have directly contradicted their clinical judgment. These practices not only compromise quality and frustrate doctors and patients, they also add administrative costs to a system that already spends more on paperwork than any other health system in the industrialized world.

The Patient Protection Act

Both consumers and caregivers need protection from a health care system in which concern for the bottom line leads to excessive micro-management. If health plans can drop caregivers from their provider lists without explanation and without recourse for providers, nothing stands in the way of some of the most predatory practices we see today. Doctors are dropped because they spend too much of the health plan's money—even if their patients are older or sicker or for other legitimate reasons need more health services. Health care providers too often are pitted against their patients when they decide whether or not to refer the patient to a specialist. In areas of the country where a few health plans dominate the market, every time a provider is dropped, thousands of families lose the continuity of care they had with doctors they may have seen for years. We cannot accept such attacks on the doctor-patient relationship.

I have introduced the Patient Protection Act to ensure that health plans act responsibly toward doctors and patients. It would require health plans to have publicly available standards for utilization review and for hiring and retaining doctors and other caregivers. They would have to provide explanations to those whose contracts are not renewed or who are dismissed, and to establish a peer-review process to give caregivers an opportunity to appeal such decisions.

The need for the standards and due process rights provided by the Patient Protection Act is likely to grow

as the health care market becomes dominated by fewer and fewer health plans.

In an effort to control the market, health plans are increasingly integrating, both vertically and horizontally, and more giant insurers are merging. Recently, two of the largest insurance companies, Metropolitan Life and Travelers, announced plans to merge their health care operations, bringing the "big five" of the Alliance for Managed Competition down to the "big four." Closer to home, in Minnesota, consolidation of market share by health plans has been accelerating, with just three health plans now dominating health care in our state.

These market changes do not necessarily produce more efficient plans. A recent study by the California Medical Association, for example, found that 25 HMOs in California spent 15 percent or more of their revenues on administrative costs and profit in 1992, including 10 that spent at least 20 percent—and two that spent more than 30 percent!—of their revenues on these non-medical costs.

Access, Quality, and Cost Control

Most of the reform proposals in Congress would correct some of the worst abuses in the insurance market, but they rely on market forces that are likely to encourage large health plans to organize the health system. These changes may further reduce physicians' clinical autonomy and perpetuate inequities in the provider payment system. These market proposals also are likely to reduce patient choice of doctor and to reinforce inequities in patient access to care according to the type of plan in which the patient is enrolled. And they may not even control costs effectively.

Physicians and other caregivers have told me their concerns about how health care reform will shape the future of our health system. They want health care reform to protect clinical autonomy and improve quality, as well as control costs. They fear that reform may, instead, give insurers greater control over the health care market, and thus greater domination of caregivers' clinical decisions and patients' choice of doctors.

To address these concerns and assure that health care reform improves access, quality, and cost control, I believe that any proposal should guarantee the following:

Universal coverage. Every citizen and legal resident should be covered—not 91 percent or 95 percent.

Comprehensive benefits. Every covered person should have access to the full range of medical services, including prevention, mental health and substance abuse treatment, rehabilitation, and long-term care.

Affordable health care. Health care coverage and services should be affordable to every working family and individual, based on a fair contribution by employers. The contributions of low-income persons, as well as those from small employers, should be subsidized as necessary. The growth of health care costs should be controlled to keep medical care affordable to society.

Freedom of choice. Every person should have an equal choice of doctor and health plan.

Public accountability. Health plans and caregivers must be accountable to enrollees and to those who pay for the system.

My single-payer proposal, the American Health Security Act, is the simplest and most effective way to achieve these goals. This is not just a matter of opinion. Researchers and policy analysts have carefully compared single-payer systems with our current system and have examined single-payer and managed-competition proposals. Their findings have been reported in the *New England Journal of Medicine* and other journals, as well as in reports from the Congressional Budget Office, the General Accounting Office, and Consumers Union. The conclusions from these studies are overwhelmingly clear:

★ A single-payer system is by far the most effective way of reducing administrative costs and controlling the growth of health care costs. This is true both in comparisons of the Canadian single-payer system with the current system in the United States[1,2] and in estimates of the costs of managed-competition and single-payer reform proposals.[3,4]

★ A single-payer system is more effective in providing equitable access for patients because there is only one tier of coverage. All persons have comprehensive coverage, and, for any given service, providers receive the same fee for all patients. Every patient has complete choice of doctor in a single-payer system.

★ A single-payer system offers the best prospect for maintaining and improving the quality of care. The American Health Security Act would remove the perverse financial incentives that distort medical practice today. Further, it proposes a publicly accountable systems approach for evaluating and improving medical practice that would be highly sensitive to providers' and patients' views about quality. Where care coordination is called for in treating chronic conditions, the act calls for peer review by equivalent professionals, financial independence for reviewers, timely decisions, and an appeals process.

The alternative health care reform strategies—managed competition and single payer—would have distinctly different impacts on quality. Managed-competition proposals rely on price competition among health

plans to keep down health care costs, a strategy that is likely to reduce the quality of care.[5] This approach uses financial incentives to encourage patients to switch from one plan to another as premium costs change, disrupting the continuity of their relationship with a provider. These proposals also count on plans terminating contracts with doctors who are more costly than other providers, thus severing doctor-patient relationships. Such disruptions would reduce the effectiveness of preventive care and care for chronic conditions.

Conversely, a single-payer system would enable patients to choose their physician without additional costs. A single-payer system also enables caregivers to choose the practice style they prefer—fee-for-service or a capitated health plan—and assures freedom from intrusive second-guessing by insurers.

Most Americans do not care what their health system is called. They care about how they are affected by it. Patients are likely to find certain advantages of the single-payer system very appealing—namely, universal and secure coverage, affordability, effective cost control, free choice of physician, and administrative simplicity. These are the very qualities of the single-payer system that have made Canadians, according to numerous surveys, more satisfied with their health care system than Americans are with theirs.[6] And these are some of the same characteristics that providers like about single payer.

The financing for my single-payer plan is far simpler and fairer than any of the managed-competition proposals and can cover a wider range of benefits. Health care coverage would be financed by replacing private premiums with public premiums. Instead of private insurance plans charging individuals and businesses based on how sick enrollees are—regardless of income or profits—the public plan would be progressively financed. Small employers—those with fewer than 75 full-time employees earning an average wage of less than $24,000—would contribute just 4 percent of payroll. Larger employers would pay 8.4 percent of payroll. Individuals will pay a 2.1 percent levy on their taxable income. In addition, a 50 percent excise tax would be imposed on cigarettes and handguns. These funds would go into a dedicated health care trust fund, similar to the Social Security trust fund, so they could be used only for this health program.

The role of the public plan would be limited to collecting the revenues and paying the bills. Services would be delivered by the same private- and public-sector providers as they are today.

Compared with what we now pay, or what we would expect to pay under managed competition, my plan would be cheaper and stay cheaper over time for the vast majority of individuals, businesses, and the nation.

I believe that single payer is the best reform strategy for providing quality health care at an affordable cost for all Americans. I am also working closely with President Clinton and Hillary Rodham Clinton and with the Senate leadership to make health care reform as progressive and positive as possible. I have successfully introduced close to 75 amendments to improve the president's original proposal and the version of the Health Security Act that was approved by the Senate Labor Committee, of which I am a member. These changes include:

★ An option for states to establish a single-payer system;

★ More extensive benefits for mental health and substance abuse treatment, preventive services, and services for the disabled;

★ The due process guarantees of the Patient Protection Act for consumers and caregivers;

★ Provisions for making health services more affordable for people with low incomes, including protections and improved funding for "essential community providers";

★ Provisions to help patients and caregivers establish their own health plans, independent of insurance companies; and

★ Provisions to strengthen quality of care standards.

During the last four years, I have had the opportunity to work closely with many physicians from Minnesota and across the nation in the development of these proposals. As physicians look to the future, I believe growing numbers will see that—because it assures universal coverage, affordability, choice of provider, and public accountability—single payer is the best option for reforming the U.S. health care system. **MM**

U.S. Sen. Paul Wellstone is the author and chief Senate sponsor of the American Health Security Act, a single-payer reform proposal.

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Managed Competition

Using Market Incentives to Control Costs, Quality

U.S. Sen. Dave Durenberger

For decades, the political establishment in Washington, D.C., has been nervously skirting the issue of health care. This year—at long last—the health care cost spiral is so marked as to make Congress sit up and take notice.

The problem that has succeeded in concentrating Washington's attention on health care is cost. One of the major pitfalls in the reform process is that too often, rhetoric has distracted the policymakers from that central truth. In 1994, the issue too often became "universal coverage." But to talk about universal coverage as the fundamental principle of health reform is to put the cart before the horse.

In fact, we have universal coverage right now. Everyone who needs health care gets it. But we as a society are paying too much for it. In effect, the private owners of health insurance are subsidizing the emergency-room care of the uninsured, and we are doing very little to cure the pathologies that lead to this very expensive kind of last-minute intervention.

Partly as a result of this focus on intensive care—the so-called "medicalization" of health care—health care costs are projected to consume 20 percent of America's gross output by the year 2004. That amounts to $2.22 trillion per year. In order to avoid this fate, we will have to change the dynamics of how health care services are delivered.

If we don't change the system fundamentally, we'll make very little headway against the cost spiral. The long-range cost projection under the Clinton bill is extremely telling in this regard; it predicts health costs at 19 percent of the GNP in 2004. Are we really going to risk the governmentalization of health care—and all the diminished quality that entails—just to make the insignificant change from 20 percent to 19 percent?

We can see the result of governmentalization of health care in countries that have adopted the "single-payer" system—shortages, waiting lists, hospital closings, and overall reductions in quality. In fact, to see the shortcomings of the single-payer system we need only look at the one we have created in our own country. Medicare and Medicaid are a single-payer system for those over 65, the poor, and the disabled, and this system can only survive by shifting its costs to the private sector.

There is a better way. I believe that by building on actual, existing market approaches from Minnesota and other regions, we can bring the cost of health care down to 10 percent of the GNP by 2004. Indeed, we must. The current speed of cost growth is not sustainable, either for our economy or our society. The approach I propose to getting health care costs in line is based on our experience in Minnesota and has become broadly known as managed competition.

Managed competition means giving consumers the power to choose among health plans that compete on the basis of price and quality. This is the only way to achieve the true goal of health reform: making everyone's health care costs affordable, not chasing an illusory 100-percent enrollment in a government or private program.

The only way to guarantee universal coverage that is affordable—because it can and will be paid for—is to get quality and value from what we buy. Managed competition means reforming the rules and incentives to make this happen. I believe that a Congressional majority exists in favor of this kind of cost-containing market reform, and that if partisan politics prevent us from acting on it this year, it will be a missed opportunity of truly historic proportions.

A health reform bill worthy of the name should establish national rules for local markets, nationwide insurance reform, real buyer power through co-ops and associations, and medical practice reform. It should include antitrust, malpractice, and medical liability reform; streamlining of administrative and information systems; comparable and comprehensive standard health plan benefits; and coverage reform.

Health reform should give to every senior citizen, every disabled citizen, and every low-income American the right to buy what every person in Congress has—a private, local, accountable health plan from a choice of at least three plans, one of which offers a choice of doctors.

The goal of every single one of these reforms is to empower health care consumers. If individual Ameri-

cans have the power to make an annual choice among health plans, that's a responsibility they will take seriously. They, the patients, will be America's health care cost containers—not some fiendishly complex web of distant health care bureaucracies.

If, after all these reforms are implemented, any health market does not reach 95 percent coverage in eight years, we'll know what to do about it and how to pay for it. But the absolutely essential first step is to fix the system. I think that by the time those eight years are up, the verdict will be in: a health care system based on managed competition will have succeeded in bringing down costs far enough to solve, in large measure, the problem of health care access.

The track record of this approach so far—and it's been attempted in various places—is impressive. For example, Paul M. Ellwood, M.D., reports that patients in a number of markets determined that they simply didn't need as many prostatectomies as were being performed. In Denver, when patients started getting some good information, the number of prostatectomies dropped 40 percent. In Seattle, they dropped 60 percent. The reason these markets had so many prostatectomies to begin with was the unhealthy incentives embodied in the concept of fee-for-service medicine—basically, the more prostatectomies you do, the more you get paid.

That's the exact opposite of the incentive structure we need if we're going to succeed in bringing down health care costs.

Under the kind of market approach I favor, the incentive would be for consumers and providers to avoid unnecessary procedures. Consumers would judge health plans not on how many things they did, but on how satisfied the patients were with their care. In other words, let's do what works, not necessarily what is most expensive.

Another example: A 1990 Met Life study found that the cost of treating conditions of the urinary tract varied by a whopping 70 percent in a single market. Patient satisfaction didn't vary—but the cost varied a great deal. Some doctors charged less than $300 for the treatment; others charged more than $500. Everybody got paid, and there was no incentive for anyone to worry about the cost.

Under the managed competition market reforms I support, there would be a system of competition among accountable health plans. If health plans had to compete with each other on measures of price and quality—with consumers able to compare them with relative ease—we would see the high end of that $300 to $500 price range drop very quickly.

If we establish a system of national rules for competition among providers, consumers will be in the driver's seat. That's the only way to achieve durable cost containment acceptable to the public.

Some people have expressed the concern that this managed competition system will lead to market domination by "mega-managed care" corporations. That's why it's so important that the national health care system be based on the principle of *national* rules for *local* markets. The goal of the reforms I support is to make competition work at the local level—with plans competing against each other in the local market. *All* plans will be judged by *local* consumers on the basis of price and quality, and the plans that satisfy their patients will be rewarded.

To Minnesota's health care community, there should be nothing shockingly new in these ideas. These concepts of health care delivery have been working to keep health costs down in our state for many years.

As long ago as October of 1980, I was challenging my fellow hospital trustees in Minnesota to make managed competition-style reforms a national reality. In a speech to the East/West Metro Hospital Trustee Council, I warned that "meaningful competition may just be our last defense against regulation. The kinds of activity we see here in the Twin Cities need to be explored and expanded upon in other areas of the country."

Even then, it was becoming apparent that America could not long sustain a spiraling of health costs. And today, the choices are even clearer: Can we, the health care consumers of America, bring this system under control and make it work for us? Or are we going to be forced to surrender the health sector completely to government's regulatory bureaucracy?

Minnesota votes for consumer choice and managed competition. **MM**

Dave Durenberger, a Republican, is the senior U.S. senator from Minnesota.

Sleepiness and Sleep Disorders

Causes and Consequences

Mark W. Mahowald, M.D.

ABSTRACT

Sleepiness and sleep disorders are prevalent in our society. Symptoms of sleepiness and complaints referable to sleep disorders have generally—and incorrectly—been discounted as being of minor importance and are often thought to be manifestations of psychological problems or character defects. It is now apporent that the cost to the American public—both to individuals and the larger society—is substantial. Sleep medicine has become established as an independent field, and knowledge of sleep, sleepiness, and sleep disorders has grown dramatically. This knowledge, when applied to individuals, will enhance the lives of potients with sleep disorders, and when applied to society as a whole, will have important socioeconomic implications.

During the past two decades, much has been learned about the nature of sleep, the determinants of sleepiness and alertness, and sleep disorders. Until recently, complaints of sleepiness and sleep problems were ignored or discounted as being of little consequence. Recent information, however, has indicated that serious consequences often accompany these complaints. Following are just a few identified by the National Commission on Sleep Disorders Research:[1]

- In 1990 in the United States, 200,000 motor vehicle accidents were caused by drivers falling asleep at the wheel.
- Nearly one-third of all driver fatalities in heavy trucking accidents are due to sleeping at the wheel.
- The official cause of the Exxon Valdez, Bhopal, Challenger, Chernobyl, and Three Mile Island disasters was fatigue-related impairment of judgment and performance in the workplace.

Sleep complaints and disorders are prevalent and costly: Forty million Americans suffer from chronic sleep disorders, 95% of these are undiagnosed and untreated; an additional 20 to 30 million people experience intermittent sleep-related problems. In 1990, the direct cost of sleepiness and sleep disorders to the American public was $15.9 billion. Indirect costs may have added another $150 billion.

Despite these staggering statistics, the average medical student in the United States is exposed to less than two hours of instruction on basic sleep in the medical school curriculum.

Normal Sleep

There are three states of mammalian being: wakefulness, non-rapid eye movement (NREM) sleep, and rapid eye movement (REM) sleep. Each of these states has its own distinct neuroanatomic, neurophysiologic, and neuropharmacologic mechanisms and behavioral features. There is no single anatomic site responsible for all the manifestations of a given state. Most of the variables that result in a given state are generated in the brainstem (especially the pons) and basal forebrain regions.[2] Neurophysiologic and behavioral features of more than one state may occur simultaneously, resulting in bizarre clinical phenomena.[3]

Determinants of Sleepiness/Alertness

A number of different physiologic variables combine to determine the level of sleepiness/alertness at any given point in time. The two most important are homeostatic and chronobiologic. The homeostatic factor is related to the duration of prior wakefulness: the longer the duration of wakefulness, the greater the pressure to sleep. The chronobiologic factor is determined by the biologic clock located in the suprachiasmatic nucleus of the hypothalamus. The biologic clock has an inherent rhythm that is entrained by the environmental light/dark cycle.[4]

Many sleep/wake characteristics are inherent and genetically determined; these include the total sleep requirement, which ranges from 4 to 10 hours,[5] and the timing of the sleep period, resulting in the tendency to be "early to bed, early to rise" (larks), and "late to bed, late to rise" (owls). There is growing scientific evidence that older adolescents require more sleep than younger adolescents, and there is a biologic tendency for the delay of their sleep period.[6,7] This

indicates that they are unable to fall asleep as early as they could when younger. With advancing age, the sleep phase tends to advance in the 24-hour period, and the intensity of the sleep phase decreases.[8,9]

Sleepiness/Sleep Disorders

The International Classification of Sleep Disorders lists nearly 100 known sleep disorders, underscoring the enormous advances made in the field of sleep medicine.[10] From a practical standpoint, most clinical sleep complaints are due to a relatively small percentage of these disorders. Physicians should ask all patients three questions: 1) Is your sleep at night satisfactory? 2) Do you tend to fall asleep at times you don't want to or shouldn't? and 3) Does anything unusual happen to you during your sleep? If the patient's response suggests a sleep disorder, it will fall into one of four main categories: hypersomnia, insomnia, disorders of the wake/sleep cycle, or parasomnias.

Hypersomnia

For too long, the symptom of hypersomnia has been attributed to depression, laziness, boredom, or some other negative personality characteristic. These conditions do *not* cause sleepiness. Obvious sleepiness occurs only in the setting of physiological sleepiness. No amount of depression will cause true sleepiness in the absence of underlying physiologic sleepiness. The most common cause of sleepiness in our society is sleep deprivation. Many sleep disorders also result in hypersomnia. The most common include obstructive sleep apnea, narcolepsy, and idiopathic central nervous system hypersomnia.

Obstructive sleep apnea syndrome is quite prevalent, affecting 4% of men and 2% of women.[11] Although the stereotype is that of a middle-aged, overweight man who snores loudly, the problem is seen in both sexes, in all age groups, in thin as well as overweight individuals, and even in the absence of snoring. Only recently have sleep researchers begun to recognize the prevalence of OSA in children.

It is important to differentiate between observed OSA and the OSA syndrome. Many individuals have OSA by observation of a bedpartner or parent. Formal evaluation is not indicated in the absence of such symptoms or findings as hypersomnia, cor pulmonale, right-sided heart failure, or polycythemia. Numerous clinical practice guidelines exist for the evaluation of suspected OSA,[12-14] and practice parameters for the use of portable recording in the assessment of OSA have recently been published.[15]

The current treatment of OSA syndrome is nasal continuous positive airway pressure. Surgical treatments include tracheostomy and uvulopalatopharyngoplasty. The use of oral/dental devices awaits further objective study.[16] In certain cases, weight loss may be effective, but is not necessarily so. The long-term success of weight reduction programs for any condition is very poor.

Narcolepsy is not a rare disease.[17,18] It affects up to one in 1,000 individuals, making it relatively as common as Parkinson disease or multiple sclerosis. Many people with narcolepsy have ancillary symptoms, such as cataplexy, sleep paralysis, and hypnagogic hallucinations, but many have only hypersomnia (monosymptomatic narcolepsy). The degree of hypersomnia is variable and often is apparent only during sedentary activities, such as reading, working at a computer, sitting in class, or driving a motor vehicle. Cataplexy, the sudden loss of muscle tone usually triggered by emotionally laden events, is frequently mild and often does not result in generalized weakness severe enough to result in falls. Typically, it is characterized by slurred speech, slackening of the facial muscles, or a feeling of impending weakness of the knees. The triggers for cataplexy are usually emotional and are often highly idiosyncratic. Laughter is a common trigger, but not in all patients.

Narcolepsy has a genetic component; more than 90% of narcoleptics have a specific HLA type. However, 30% of the general population also has this HLA type. Thus, it is clear that this HLA type is neither necessary nor sufficient to cause narcolepsy. The additional genetic or environmental factors are unknown. Because some people with narcolepsy are HLA negative, and 30% of the general population is HLA positive, there is no clinical indication for the use of HLA typing in the evaluation of hypersomnia generally or narcolepsy specifically.

Because stimulant medications are the treatment of choice for the hypersomnia of narcolepsy, it is desirable to obtain an objective diagnosis with formal sleep studies. The hypersomnia in patients with documented narcolepsy responds well to stimulant medication, with little evidence of tolerance, dependence, or abuse. The dosage of stimulants is variable, and many experts recommend using dosages that result in symptomatic improvement.[19] The ancillary symptoms of cataplexy, hypnagogic hallucinations, and sleep paralysis respond to tricyclic antidepressants. Strategically timed napping may improve symptoms of sleepiness in some patients with narcolepsy. Many patients with narcolepsy are poorly tolerant of irregular wake/sleep patterns, including shift work.

Idiopathic CNS hypersomnia is a condition that presents like narcolepsy—but with hypersomnia as the only symptom. The diagnosis is made by formal sleep studies, and the condition is treated with stimulant medication.[20]

Insomnia

Insomnia affects up to 30% of the adult population. Insomnia is a symptom, and not a disorder in and of itself. It is often the symptom of many underlying medical, psychiatric, and psychological conditions. Insomnia may also be the presenting symptom of other primary sleep disorders. For practical purposes, insomnia may be categorized as transient (a few nights), short-term (less than a month), or chronic (longer than a month). Most cases of insomnia can be readily diagnosed and managed in the primary care setting. Once possible underlying medical or psychiatric conditions have been identified and treated, a combination of behavioral and pharmacologic therapy is often very effective.[21] Sed-

ative-hypnotic treatment can be effective, particularly in short-term insomnia, and may serve to prevent the development of chronic insomnia. Effective agents include the benzodiazepines and a newer non-benzodiazepine, zolpidem. The risk of tolerance, dependence, and abuse in this patient population appears to have been greatly exaggerated (Schenck CH, Mahowald MW, unpublished data, July 1994). Aggressive management is justified because of the known consequences of insomnia on mood and performance.

Wake/sleep cycle disorders

The wake/sleep schedule disorders fall into two categories: primary (malfunction of the biologic clock per se), and secondary (caused by environmental effects on the underlying clock). The secondary disorders (such as jet lag and shift work) are usually immediately apparent to the clinician upon simple questioning of the patient. The primary disorders may be much more difficult to diagnose, as they typically masquerade as other disorders, such as hypersomnia, insomnia, substance (sedative/hypnotic or stimulant) abuse, or psychiatric conditions. The more common primary wake/sleep schedule disorders include delayed sleep phase syndrome, advanced sleep phase syndrome, non-24-hour sleep phase syndrome, and the irregular sleep phase syndrome. These disorders are beyond the scope of this overview and are reviewed elsewhere.[22]

Identification of these often disabling disorders is important, because effective treatments exist. These include chronotherapy, benzodiazepines, and phototherapy. Melatonin administration appears promising; however, the agent is not currently available.

Parasomnias

Parasomnias are defined as unpleasant or undesirable behavioral or experiential phenomena that occur predominately or exclusively during sleep.[23] These were initially thought to represent a unitary condition, often attributed to psychiatric disease. Recent clinical and polygraphic analyses have revealed that they are, in fact, the result of a large number of completely different conditions, most of which are diagnosable and treatable. Most are not the manifestation of psychiatric disorders and are far more prevalent than previously thought.

Although there are many different parasomnias, only a few, listed below, account for the vast majority of cases:

Disorders of arousal: These occur on a continuum ranging from confusional arousals to sleepwalking to sleep terrors. These phenomena are extremely common in children and are also much more common in adults than previously suspected. Contrary to popular opinion, they may even begin in adulthood and are uncommonly associated with significant psychiatric disease. Treatment with medication or hypnotherapy is often effective. An interesting variant—the sleep-related eating disorder—has recently been recognized.[24]

REM sleep behavior disorder (RBD): This condition presents with the complaint of prominent motor behavior associated with vivid dream-like mentation ("acting out of dreams"). Patients with RBD lack the paralysis associated with REM sleep, which is readily apparent on polysomnographic study. Medical attention is often sought when injury to the patient or bedpartner is feared. RBD is seen predominately in older men and responds dramatically to clonazepam.[25]

Nocturnal seizures: Exclusively nocturnal seizures that present with extremely bizarre behaviors are not uncommon. They are routinely misdiagnosed because of their tendency for bizarre behaviors, exclusively nocturnal timing, and clustering in time. Treatment with anticonvulsant medication is usually effective.[26]

Psychogenic dissociative disorders: These occur most frequently in women and may mimic complex sleepwalking or nocturnal seizures. A history of childhood physical or sexual abuse is almost always present but is often difficult to obtain. These spells may occur predominately or exclusively during the sleep period. Treatment of these conditions involves specialized treatment by an experienced psychotherapist.[27]

Many people experience occasional unusual behaviors during sleep. Such behaviors should be evaluated by a sleep center experienced in these disorders if they: 1) are potentially violent or injurious, 2) are extremely disruptive to other household members, 3) result in the complaint of excessive daytime sleepiness, or 4) are associated with medical, psychiatric, or neurologic symptoms or findings. The patient's history may suggest a tentative diagnosis; however, experience has shown that in most cases, the definitive diagnosis cannot be made by history alone and must be confirmed by formal polygraphic study. Empiric medical treatment is to be discouraged, because the therapy for one disorder may actually worsen another.

Evaluation of Sleep/Wake Complaints

There are many accredited sleep disorders centers in the country, and they are experienced in the evaluation of a wide variety of sleep/wake complaints. Too often, these centers are erroneously thought of as only diagnostic laboratory facilities. In fact, the first step in the evaluation of sleep/wake complaints is clinical. Many patients seen in sleep centers receive a diagnosis and effective treatment plan without formal sleep studies. Often, a physician may consult by phone with the sleep center to determine the appropriateness of a potential referral, and the center may suggest initial management before the physician decides whether to make the referral.

Clinical evaluation

The evaluation of sleep complaints begins with a thorough sleep history and focused physical examination. Particular attention should be paid to the cardiopulmonary, neurologic, and psychiatric examinations. A meticulous history of wake/sleep function must be obtained. Supporting information from bedpartners, other family members, co-workers, or caregivers is usually required for a complete and accurate assessment of sleep behaviors. Prolonged sleep/

wake diaries completed by the patient or observer may give a simple overview of wake/sleep patterns not apparent by clinical history.

Technical evaluation

If the sleep/wake disturbance is clinically bothersome and cannot be diagnosed by history alone, procedures to obtain objective information regarding the quality, quantity, and/or timing of sleep should be performed. It is recommended that the patient be seen by or discussed with the sleep specialist prior to the study, because each study can be tailored to the specific clinical situation, enhancing the value to both the patient and referring physician.

Polysomnography (PSG): The technology used for the diagnosis of sleep disorders employs standard electrophysiologic recording systems.[28] The basic PSG format has been standardized and includes continuous monitoring of eye movements, at least one channel of electroencephalogram (usually C3/A2 or C4/A1), respiratory parameters (at minimum, airflow), electrocardiography, submental electromyogram, and anterior tibialis electromyogram. Multiple respiratory parameters must be monitored to evaluate sleep-disordered breathing. Other parameters may be monitored as clinically indicated, such as extensive EEG for parasomnias, esophageal pH for gastroesophageal reflux, or penile tumescence for erectile function. The American Electroencephalographic Society has outlined specific polysomnographic recording techniques,[13] and sleep-stage scoring techniques have been standardized.[29]

An all-night PSG allows sleep to be accurately quantified and sleep stages fully characterized. It is also possible to determine the presence of sleep architecture disruption, cardiopulmonary abnormalities, sleep-related motor activity, and other sleep-associated disorders. Visual scoring and interpretation of polysomnograms is the currently accepted standard. The reliability of computer-aided systems to evaluate sleep disorders awaits objective, published verification.[30] The complex nature of normal and abnormal sleep, together with complexities of the physiologic recording equipment (artifacts and signal maintenance) challenge the utility of such systems.[3,31]

Multiple sleep latency test (MSLT): The MSLT is a standardized and well-validated measure of physiologic sleepiness.[32] Parameters monitored are the same as those for basic PSG. The MSLT consists of four to five 20-minute nap opportunities offered at two-hour intervals. The MSLT is designed to quantitate sleepiness by measuring how quickly an individual falls asleep on sequential naps during the day, and to identify the abnormal occurrence of REM sleep during a nap. For each nap, the latency between "lights out" and sleep onset is recorded. Pathologic ranges of sleep latency have been carefully defined. A mean latency of five minutes or less indicates severe excessive sleepiness. The number of naps during which REM sleep appears is also noted. Proper interpretation requires a preceding night PSG to measure the quality and quantity of sleep obtained immediately prior to the MSLT. The MSLT is a powerful tool in quantifying daytime sleepiness and in differentiating the subjective complaints of "sleepiness," "tiredness," and "fatigue."

Actigraphy: Analysis of sleep diaries may be insufficient to verify a tentative diagnosis in patients with suspected wake/sleep cycle abnormalities. In such cases, definitive objective data may be obtained by actigraphy, a recently developed technique to record activity during wake and sleep that complements the subjective sleep log. An actigraph is a small wrist-mounted device that records the activity plotted against time—usually for a week or two. When data collection has been completed, the results are entered into a personal computer, where software displays activity versus time. The accompanying figure shows an actigraphic report and demonstrates how the rest/activity pattern is apparent at a glance. There is high correlation between the rest/activity recorded by the actigraph and the wake/sleep pattern as determined by PSG.[22]

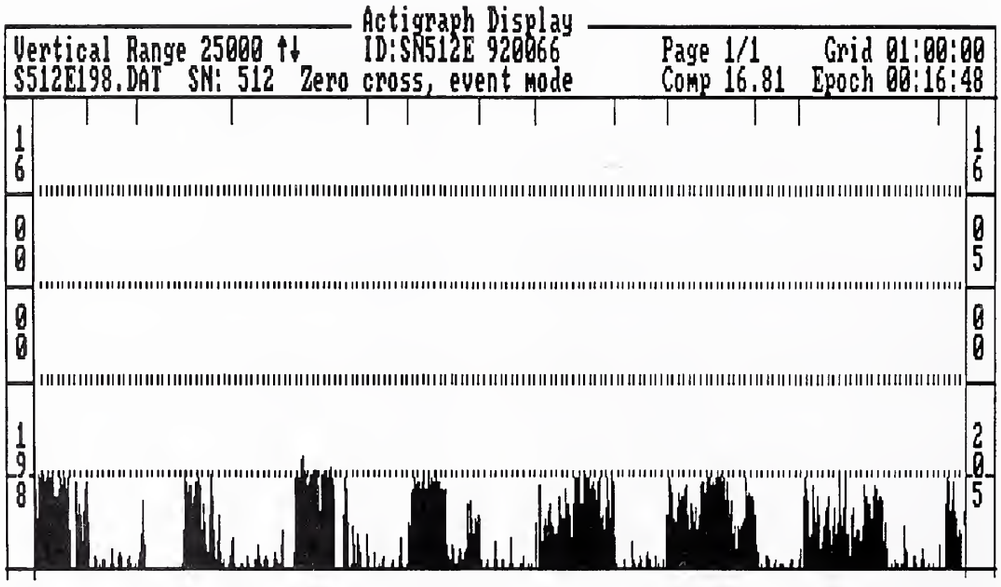

Figure: Sample of actigraphic report: vertical bars represent activity levels plotted over seven consecutive 24-hour periods, allowing rapid objective assessment of the rest/activity pattern, which correlates highly with the wake/sleep pattern.

Sleep Deprivation in Society

There is compelling evidence that sleep deprivation in our modern society is widespread. Today, Americans sleep 1.5 hours less than our predecessors did a century ago. There is no reason to believe that they needed more, or we less, sleep. This progressive societal sleep deprivation is due to many factors: the jet plane allowing rapid time-zone shifts, the electric light facilitating shift work, and economic and technical factors that promote shift work and encourage staying up late (all-night TV, 24-hour stock exchanges, the 24-hour "information highway").

Perhaps one of the most important factors is the widespread misperception that sleep is negotiable—"a waste of time." The past few generations have been raised with the idea that sleep deprivation is "macho," or an indicator of a most desirable personal trait. Conversely, sleeping is commonly perceived as a character defect—particularly napping, going to bed early, or "sleeping in" on weekends. Too often, sleeping is attributed to depression, laziness, slothfulness, boredom, or work avoidance. None of these negative attributes causes sleepiness in the absence of physiologic sleepiness.

What is now known, however, is that sleep deprivation is always associated with impaired performance—in the classroom, in the workplace, and behind the wheel. The well-documented consequence of sleep loss is impairment of performance—particularly at tasks involving sustained attention.[33] This impairs judgment, reasoning, reaction time, and learning.

Falling asleep on the job is common, particularly in shift workers. Such impairment of performance can have potentially grave consequences: pilots, for example, not infrequently fall asleep in the cockpit, and nuclear power plant workers frequently fall asleep on the job.[34] The common perception of increased personal and economic productivity achieved by sleep deprivation is not borne out by the facts. In some fields, legislation has been enacted restricting duty hours. This is already occurring in medical training programs.[35]

Implications

Recent advances in the understanding of sleepiness and sleep disorders have professional and societal implications. In professional practice, the clinician is becoming aware that sleep/wake complaints are usually associated with a diagnosable and treatable underlying medical condition—that most such complaints or symptoms are not the manifestation of personality flaws or psychiatric problems, and that such complaints, if undiagnosed and untreated, are associated with significant personal misery and important socioeconomic consequences.

In the larger society, when new and important scientific information becomes available, the medical profession has an opportunity and a responsibility to use that information to attempt to influence social behavior—at both a personal and policymaking level—to improve quality of life and enhance public safety. Progress is being made in the realm of sleep and sleep medicine. Based upon scientific data, for example, the Minnesota Medical Association has passed a resolution encouraging later school start times for older adolescents. Additionally, the Center for Sleep Disorders Research in the Heart, Lung, and Blood Institute of the National Institutes of Health is embarking on an educational program aimed at the general public and physicians regarding sleepiness and sleep disorders. This campaign will be similar to the successful educational programs previously developed by that institute for hypertension, smoking, heart attacks, cholesterol, and obesity.

Education of the general public, medical students, and practicing professionals can easily and readily prevent or reduce the tragic personal and societal consequences of sleepiness and sleep disorders. The task is to disseminate this information, debunk the myths about sleep, and to take seriously the signs and symptoms of sleepiness and wake/sleep complaints. MM

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The Monitor
News For Minnesota Physicians

Announcements

Vote in the Primary

The primary election will be held Tuesday, September 13. This is an extremely important primary. The only candidates who will be on the ballot in the general election on November 8 are those who win in the primary on September 13. Primary election losers cannot run as independent candidates even if they are incumbent state officers. To find out where to vote, call your county auditor. If you will be unable to go to the polls, you may obtain an absentee ballot by contacting the county auditor. Absentee ballots must be received by September 13.

MMA Conference for CME Planners

The Third Annual Conference for CME Planners will be held October 21 at the Northland Inn in Brooklyn Park. Topics for the day-long conference include discussion of new technologies, potential effects of health system reform on CME, and an update on CME requirements for physician relicensure in Minnesota. For futher information, call Jane Phillip, Minnesota Medical Association, 612/378-1875 or 800/999-1875.

MEDPAC Endorses Peterson

The MEDPAC Board voted August 11 to recommend that AMPAC endorse the incumbent, Rep. Collin Peterson, DFL, in the seventh-district congressional race. Peterson is a co-sponsor of the Health Care Antitrust Improvement Act of 1993 and the Patient Protection Act. The board's other recommendations for endorsements in congressional races were published in the August *Monitor*.

MMA Meets With Clinton Administration on Reform

The Minnesota Medical Association supports the national health system reform goals of universal coverage, antitrust reform, fraud and abuse changes, the Patient Protection Act, and medical liability reform. Paul S. Sanders, M.D., MMA CEO, and A. Stuart Hanson, M.D., MMA past president, argued in favor of these objectives at a July 26 meeting with Ira Magaziner of the Clinton administration and with representatives of the medical societies of California, Wisconsin, and Vermont. Magaziner sought physician support for universal coverage and mandatory employer contributions. Sanders and Hanson reaffirmed MMA support for universal coverage, but said the MMA considers the employer mandate one possible means to achieve that goal rather than a necessary part of health system reform.

Sanders and Hanson presented the MMA's position, which is summarized below.

Antitrust Reform

Antitrust reform and changes in the fraud and abuse laws are needed. Laws should establish "safe harbors" within which physicians can form networks to compete with insurance companies and other third-party payers, and should protect collective negotiations by physicians with entities that set budget targets and other standards.

Magaziner said the Clinton administration is aware of the need for antitrust relief, but wants to achieve it through Justice Department regulations rather than federal legislation. "The redefined world of health reform will permit regulatory changes to effect needed antitrust changes," Magaziner said. Sanders and Hanson said they were skeptical that physicians' antitrust problems could be solved through regulations.

Patient Protection Act

The AMA's Patient Protection Act, sponsored by Sen. Paul Wellstone, D-Minn., and Rep. Collin Peterson, D-Minn., would guarantee people the information they need to make wise choices about health plans. It would require plans to disclose any policies that restrict access to physicians or services and to reveal the standards used to select network physicians. The act guarantees physicians due process, thus protecting them from being forced out of a network for providing appropriate care. It would also preserve patient choice by requiring plans to offer patients at least three types of coverage and an option allowing them to see a physician outside their plan. It would not, however, require plans to accept "any willing provider," as critics claim. The AMA dismisses as "absolutely ludicrous" charges that the act is anti-managed care.

Medical Liability Reform

Medical liability reform would allow money now spent on defensive medicine and malpractice costs to be spent instead on patient care. The MMA supports a $250,000 cap on awards of non-economic damages, a sliding scale for attorney contingency fees, periodic payments of all

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awards, a ban on punitive damages, and collateral source offsets. A recent study projected up to $35 billion in savings over five years from curbs on defensive medicine.

The MMA opposes federal provisions that would preempt stronger state laws, thus turning back the clock for Minnesota and other states that have implemented tort reforms. The MMA also opposes provisions in the Senate bill and House Judiciary Committee language that would mandate non-binding alternative dispute resolution and allow practice guidelines to be used as evidence.

Update

As the *Monitor* goes to press, the situation remains fluid. Senate Majority Leader George Mitchell, D-Maine, is still revising his bill to win votes. Sen. Robert Dole, R-Kan., introduced a bill calling for insurance reform. Sen. Dave Durenberger, R-Minn., is part of a mainstream coalition proposing a bipartisan plan for deficit reduction and insurance reform. Senate liberals, including Wellstone, want to strengthen universal coverage, cost containment, and affordability provisions.

In the House, action on the bill drafted by Majority Leader Rep. Richard Gephardt, D-Mo., is on hold until the Congressional Budget Office completes its analyses, which may take weeks or even months. The AMA does not support the Gephardt bill mainly because of its proposal to create a new Medicare Part C system, which the AMA fears will lead to a single, bureaucratic government health system. The AMA supports a bipartisan House proposal, sponsored by Rep. J. Roy Rowland, D-Ga., with no tax increase or employer mandate. It calls for insurance reforms and subsidies funded by cuts in Medicare and Medicaid growth. It would reach 90 percent coverage by 2004, a 5 percent increase in current coverage.

In this rapidly changing political arena, the MMA continues to focus on health system goals rather than supporting a particular bill. • • • • •

St. Cloud Physicians Form Network

In St. Cloud, site of this year's MMA Annual Meeting, physicians are forming a physician-governed network based on the concept of a "clinic without walls" but tailored to meet local needs. The Stearns-Benton County Physician Organization currently unites 115 physicians in an integrated delivery system. Without merging their assets or relocating to new clinics, these physicians have pooled resources to form a network that they expect will be ready to contract with third-party payers in about six to nine months.

Efforts to integrate began in November 1993 when physicians formed a task force, chaired by Nelson D. Sirlin, M.D., to study the possibility of a physician network. "We really believe independent physicians can provide managed care as well as corporate physicians can," Sirlin said. A physician-owned network offers its members several benefits, he said. It can help members develop economies of scale, link information systems, share billing information, and provide centralized managerial services. It also offers an opportunity to improve patient care. Physicians are in the best position to cut costs without compromising quality of care. For instance, if one treatment or procedure is more expensive than another, physicians can look at the outcomes and decide whether the higher cost is justified. If patients recover just as well with the less expensive treatment, that's the one physicians will recommend to their colleagues. On the other hand, if the more expensive procedure results in significantly better outcomes, it should be used despite the cost.

The idea of forming a network in the St. Cloud area had been brewing for some time. Physicians in the area attended regional seminars on MinnesotaCare co-sponsored by Stearns-Benton County Medical Society and by the MMA. At these meetings, physicians learned about changes in the marketplace that were starting to occur.

"We have some concerns that the large systems that are buying up physician practices may bypass St. Cloud for referrals," Sirlin said. "St. Cloud is determined to maintain its status as a secondary medical center."

After studying various options, the task force recommended that area physicians pursue the idea of an independent physician organization. Initially, some physicians were reluctant to organize because they had been burned in the early 1980s, said Jeffrey Blair, executive director of the Stearns-Benton County Medical Society. At that time, central Minnesota physicians' efforts to integrate brought down fines and sanctions from the attorney general, who called their arrangement a violation of antitrust.

Now physicians feel more confident that they can proceed without fear of violating antitrust laws, said Blair, but he added that they are not at a "complete comfort level." The change in thinking occurred after physicians attended MMA MinnesotaCare seminars addressing antitrust issues, held discussions with attorneys, and listened to assurances from Paul R. Kempainen, assistant attorney general. Kempainen said that problems with antitrust arise when providers agree to cooperate in setting the price of services or if one group of providers agrees to exclude others. A single network in an area is not illegal in and of itself. It is, however, unlawful to obtain a monopoly by locking out competitors. He advised physicians to seek approval from the commissioner of health for arrangements that could otherwise violate state antitrust laws.

The Stearns-Benton Physician Organization is open to physicians not only in the St. Cloud metropolitan area but also in smaller places throughout central Minnesota. The physician network is still a work in progress. In the future it may develop into a community integrated service network or a cooperative. • • • • •

Announcements

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Beyond Broken Bones and Black Eyes: Can You Identify Abuse? How Will You Respond?

On Friday, November 4, the Minnesota Medical Association and the Hennepin and Ramsey county medical societies will present an anti-violence and abuse conference at the Radisson South Hotel in Bloomington. The conference will focus on the warning signs of abuse, methods of intervention, the socioeconomic impact on health care, Minnesota initiatives, and physician responsibility. Speakers will include Robert McAffee, M.D., AMA president, Susan Hadley, WomanKind founder, and Chief Judge Kevin Burke. The registration fee is $95 for members and $115 for non-members. For more information, contact Cathy Graci, 612/362-3704 or 800/999-1875. Mark your calendar and plan to attend this important seminar.

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AMA Protests Denial of MMA Request for a Safe Harbor

In a letter to June Gibbs Brown, U.S. inspector general, the AMA expressed concern about the Office of Inspector General's denial of the MMA's request for a safe harbor provision to protect the non-routine waiver of Medicare Part B copayments and deductibles for indigent patients. The AMA requested a reversal of this decision and asked that the safe harbor be created.

MMA Wins the ASAE Summit Award

The Minnesota Medical Association has won the top award in the Associations Advance America Awards program for its outstanding campaign to combat domestic violence and abuse.

From 240 entries, the MMA along with seven other associations received the highest level of recognition—the Summit Award. This award is presented by the American Society of Association Executives (ASAE) for activities that significantly benefit society and make America a better place to live.

The MMA's ongoing campaign against violence has included public service announcements, posters, and billboards urging victims of abuse to turn to their physicians for help. The MMA has also published a list of resources for victims of abuse and a list of guidelines to help physicians recognize the signs of abuse. On November 4, the Minnesota Medical Association along with the Hennepin County Medical Society and the Ramsey County Medical Society will present a workshop to help physicians recognize and respond to the signs of violence.

The ASAE Associations Advance America Awards recognize significant contributions to society by associations in areas such as education, product and safety standards, professional standards and codes of ethics, research and statistics, international activities, and community service. The ASAE is made up of more than 22,000 association executives who manage leading trade associations, professional societies, and voluntary organizations across the United States and in 44 other countries.

On behalf of the MMA, Mark Vukelich, director of communications, accepted the Summit Award at a special awards ceremony August 30 in San Francisco during ASAE's Annual Meeting and Exposition. • • • • •

MMA Supports State Suit Against Tobacco Firms

The MMA applauds Attorney General Hubert Humphrey III for taking on the nation's powerful tobacco companies in a lawsuit to recover a portion of the $350 million Minnesota taxpayers spend each year to treat tobacco-related illnesses. The action was filed August 17 by the state and co-plaintiff Blue Cross and Blue Shield of Minnesota (BCBSM), the two largest purchasers of health care in the state.

Unlike product liability lawsuits alleging that tobacco is dangerous, Minnesota's lawsuit is based on charges of antitrust violation and consumer fraud. The suit alleges that tobacco companies have conspired to suppress and distort tobacco research, defraud the public, and suppress the marketing of safer cigarettes. According to the lawsuit, tobacco executives began a 40-year conspiracy when they met in 1953 to concoct a public relations campaign to hide the dangers of tobacco.

The lawsuit seeks to recover the money paid by the state and by BCBSM to treat tobacco-related illnesses. The amount of damages has yet to be determined. In addition to damages, plaintiffs are seeking civil penalties. The suit also seeks to force tobacco companies to open their research files and to fund a truthful educational smoking campaign and clinical smoking cessation programs.

Minnesota physicians strongly support this effort to prevent unnecessary death and disease and to remedy the harm already done to their patients. • • • • •

MINNESOTACARE NEWS

MMA Comments on Waiver Request

The Minnesota Medical Association has submitted comments to the Minnesota Department of Human Services (DHS) regarding the state's request for a federal waiver that would integrate Medical Assistance (MA), General Assistance Medical Care, and MinnesotaCare; expand managed care delivery under Medical Assistance using integrated service networks and community integrated service networks; and link Medical Assistance and Medicare rate setting and data collection to Minnesota's health system reform efforts. One of the state's goals is to develop a single new managed care payment methodology for Medical Assistance and Medicare.

The MMA supports the goal of providing greater continuity of care for MA patients through managed care, but it is concerned about the vagueness of the language in the waiver requests. Many questions remain unanswered, especially regarding the proposed new rate-setting methodology. In comments to DHS, the MMA urged that MA rates be increased to a level closer to actual market rates in order to eliminate cost shifting. The MMA also expressed concern about the process to be used to enforce statewide growth limits. The waiver request mentions that under the new methodologies, Medical Assistance and Medicare would continue to be subject to state growth limits. The MMA urges that realistic rates be set even if they result in MA and Medicare fee increases greater than the state's yearly aggregate growth limits. The MMA asked to be involved in further discussions, especially those related to rate setting.

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Region Two RCB Alternate Delegate Named

The MMA Board of Trustees has appointed Terrence C. Clark, M.D., as an alternate delegate on the Region Two MinnesotaCare Regional Coordinating Board. Clark, who specializes in internal medicine and pulmonary diseases at the Duluth Clinic, was recommended by the Lake Superior Medical Society. Clark fills the post formerly held by Raymond G. Christensen, M.D., who resigned his position when the governor appointed him to the Minnesota Health Care Commission.

Prepare Now for the Survey on Revenue and Expenditure Data

• • • • • The Minnesota Department of Health required nearly 700 physician clinics to submit data on clinic revenues and expenditures for the last six months of 1993. Now the MDH plans to expand its data collection efforts to include **all** physicians, dentists and chiropractors. The MDH will use this data to determine the total health care expenditures in the state as required by MinnesotaCare law.

The 1993 data collection effort proceeded under emergency rules. Currently, MDH is revising last year's survey and writing permanent data collection rules that are not expected to be completed until late 1994. The timing could pose a problem for physicians. Although the data collection survey probably won't be mailed until late fall, physicians will be expected to submit data for all of 1994.

As the January *Monitor* advised, it's important to start collecting data now. Providers will be required to return a completed survey on 1994 data to the MDH by April 1, 1995. Providers may, however, request extensions.

Prepare for the MDH data collection survey by tracking your revenue by payer type. This activity is similar to tracking the revenue that is subject to the MinnesotaCare 2 percent provider tax.

According to the current draft of the rules, clinics with three or fewer physicians and with net revenues of less than $1 million will be allowed to complete an "easy" version of the MDH survey. These smaller clinics and solo practitioners will probably have to report only revenues by payer type and total expenditures. Larger clinics will probably be required to complete a functional category breakdown of expenditures, as well as the revenue section of the survey. The MMA will urge the MDH to keep this provision in the permanent rules so data collection will be a little easier for small clinics and solo practices.

Watch the *Monitor* for further developments. For more information, call Janet Silversmith at the MMA, 612/378-1875 or 800/999-1875.

House of Delegates Will Consider Resolutions, Set Policy at 1994 MMA Annual Meeting

The 1994 MMA House of Delegates will convene in St. Cloud Thursday, September 29, and Friday, September 30, to take action on a number of resolutions that will set MMA policy.

Reference committees, appointed by Barbara Yawn, M.D., speaker of the MMA House of Delegates, will present reports to help the House in its deliberations. After the House's first session Thursday morning, each reference committee will hold an open meeting to hear testimony supporting or opposing the resolutions assigned to that committee. All MMA members are invited to attend and may speak at the hearings. The author or a representative of the society or specialty group that submitted each resolution will be on hand to support the resolution and to answer questions. After the open hearings, the reference committees will go into executive session and prepare reports recommending action on the resolutions assigned to them.

At its second session, September 30, the House of Delegates will consider the reference committees' reports and take action on the resolutions. The House has several choices:

- Adopt. If the House adopts it, a resolution becomes MMA policy.
- Adopt as amended. A resolution is considered "amended" if there is any change in the wording of the original resolution. Amendments range from slight clarifications or corrections to more fundamental changes. They may be recommended by the reference committee, or, with the permission of the speaker of the House, on the floor of the House of Delegates. Sometimes the resolution's author will propose amendments during open testimony before the reference committee.
- Adopt a substitute resolution. Several resolutions with a similar purpose may be combined into a substitute resolution.
- Refer for study to the MMA Board of Trustees. The Board of Trustees studies the resolution and submits a report to the House at the next annual meeting.
- Refer for decision to the MMA Board of Trustees. This action gives the Board discretion to decide whether to adopt the resolution. The Board reports back to the House at the next annual meeting.
- Refer to the Board of Trustees for implementation. This procedure is used when the House wants a resolution implemented as soon as possible. The House leaves it up to the Board to decide how to implement the policy. This action is often combined with another decision. For instance, a resolution may be adopted and referred to the Board for implementation, or it may be referred for decision and implementation to the Board.
- Not adopt. Finally, the House may decide not to adopt the resolution.

As the *Monitor* goes to press, the following resolutions have been submitted.

Res. 1, Accountability of Government Peer Review Organization and Data Collection Services

Introduced by: Wright County Medical Society

Be it resolved that the MMA pursue legislation requiring all surveyors and inspectors, government or private, to include in any recommendations or requirements the statement that justifies these requirements on the basis of better patient care or cost savings. Be it further resolved that the MMA urge the AMA delegation to pursue a similar resolution and legislation on the national level.

Res. 2, Weekend Nursing Home Transfers

Introduced by: Gary D. Hanovich, M.D., delegate, Hennepin County Medical Society

Be it resolved that the MMA identify and work with those authorities who can help us change nursing home behavior to rectify this situation [premature transfer of patients from hospitals in order to beat the nursing home ban on accepting patients during the weekend] and thereby benefit our patients, our hospitals, and society as a whole.

Res. 3, Organized Medical Staffs and the MMA-HMSS

Introduced by: Hospital Medical Staff Section (HMSS)

Be it resolved that the MMA House of Delegates at its 1994 Meeting support the concept of representatives from other organized non-hospital medical staffs serving as representatives to the MMA-HMSS, and that the MMA-HMSS be authorized to draft the policy defining the eligibility criteria for the organized non-hospital medical staffs.

Res. 4, Insurance Discrimination Against Victims of Domestic Violence

Introduced by: MMA Committee on Communications

Be it resolved that the MMA adopt a policy opposing denial of insurance coverage to victims of domestic violence and abuse, seek legislation to prohibit insurance discrimination in Minnesota, and forward a similar resolution to the AMA House of Delegates.

Res. 5, Sleep Deprivation Survey

Introduced by: Minnesota Psychiatric Society

Be it resolved that that the MMA develop and disseminate a survey to the Minnesota Independent School Districts to determine the impact of the campaign [regarding teen sleep deprivation].

Resolutions continued on page 38

Resolutions *continued from page 37*

Res. 6, Sexual Discrimination and Harassment

Introduced by: Wright County Medical Society

Be it resolved that the MMA continue public educational initiatives regarding sexual discrimination and harassment, and that the delegation to the AMA pursue AMA educational initiatives on the national level, including education of the major television networks and the Writers' Guild, as well as the distribution of public service announcements.

Res. 7, Commendation of Gail L. Gamble, M.D.

Introduced by: Zumbro Valley Medical Society

Be it resolved that the MMA express its gratitude and admiration for the years of effective and competent leadership that Gail Gamble, M.D., has given to this organization.

Res. 8 and Res. 9, Bylaws Revision, MMA House of Delegates

Introduced by: MMA Board of Trustees

Be it resolved that bylaws revisions, which were approved by the MMA Board of Trustees, be adopted.

Res. 10, Mandated Content of Continuing Medical Education

Introduced by: Committee on Accreditation and Continuing Medical Education (CME)

Be it resolved that the MMA oppose any proposed legislation or government regulation that defines the subject matter of CME required for physician relicensure in Minnesota.

Res. 11, Culturally Competent Health Care

Introduced by: Hennepin County Medical Society (HCMS)

Be it resolved that the MMA study and implement ways in which increased education on intercultural issues will become a mandatory part of the training process involving medical students and residents, and that the MMA actively participate in the education of physicians throughout the state on the understanding and sensitivity toward intercultural health care, and that the MMA fully support and participate in the activities of the HCMS/United Way Intercultural Awareness Task Force and aid with administrative support of the task force.

Res. 12, Interpreters

Introduced by: HCMS

Be it resolved that the MMA work with third-party payers to pay directly for the cost of interpreters similar to the established reimbursement by managed care plans for the Medicaid population, and that the MMA pursue legislative initiatives to support the ongoing activities of those groups and organizations dedicated to improving the quality of health care delivered to intercultural communities, e.g., Community Interpreter Services.

Res. 13, HCMS Abuse Prevention Project

Introduced by: HCMS

Be it resolved that the MMA acknowledge, support, and participate in the HCMS's work in the Abuse Prevention Project.

Res. 14, Categories of Membership

Introduced by: HCMS

Be it resolved that component medical societies work closely with the MMA to establish common categories of membership throughout the state.

Res. 15, Medicare Reimbursement Inequities

Introduced by: Hennepin and Ramsey county medical societies

Be it resolved that the MMA work with the Minnesota Legislature, the governor, and the Minnesota attorney general to obtain an adequate appropriation from the 1995 Legislature that will enable the attorney general to initiate legal action against the federal government to correct the geographic inequity in Medicare reimbursement.

Res. 16, Physician Involvement With Third-Party Payers

Introduced by: HCMS

Be it resolved that the MMA work with third-party payers and encourage them to formally and significantly involve physicians in their board of directors and advisory councils.

Res. 17, Timely Nursing Home Transfers

Introduced by: HCMS

Be it resolved that the MMA identify barriers to timely transfer of patients from hospitals to nursing homes, and that the MMA work with physicians, nursing homes, and others, as appropriate, to decrease barriers to nursing home transfers.

Res. 18, Urgent Care Centers

Introduced by: HCMS

Be it resolved that the MMA conduct a study of urgent care centers in order to determine what physician qualifications are required and whether they have a formal credentialing process including the initial appointment and reappointment application, and that the MMA review and, if necessary, establish standards for physicians providing services at urgent care centers.

Res. 19, AIDS Testing

Introduced by: Range Medical Society

Be it resolved that the MMA support legislation that would treat HIV like other communicable diseases and allow HIV testing without consent prior to testing.

Res. 20, Bicycle Safety

Introduced by: Range Medical Society

Be it resolved that the MMA support legislation that mandates the use of protective head gear in the state of Minnesota.

Res. 21, Water Safety

Introduced by: Range Medical Society

Be it resolved that the MMA support legislation that mandates the use of life jackets or flotation devices in the state of Minnesota.

Res. 22, Reimbursement for Mid-Level Providers

Introduced by: Minnesota Academy of Family Physicians

Be it resolved that the MMA aggressively pursue equitable reimbursement for nurse practitioners, nurse specialists, and physician assistants working with physician supervision.

Res. 23, Health Plan Restrictions on Mental Health and Chemical Dependency Treatment by Primary Care Physicians

Introduced by: Minnesota Academy of Family Physicians

Be it resolved that the MMA support the Minnesota Academy of Family Physicians in working to remove health plan restrictions on mental health treatment by primary care physicians.

Res. 24, Retention of Physician Signature on Vital Statistics Information

Introduced by: MMA Committee on Ethics and Medical-Legal Affairs

Be it resolved that the MMA work with Department of Health representatives and communicate the MMA's concern that the automated vital statistics system retain the physician signature on the original birth and/or death certificates if retention of the signature on copies is economically feasible.

Res. 25, Mental Health Treatment Restrictions

Introduced by: Upper Mississippi Medical Society

Be it resolved that the MMA work through administrative, political, and legislative means to remove health plan restrictions on appropriate mental health and chemical dependency treatment by primary care providers.

Res. 26, Study of Single-Payer System

Introduced by: RCMS

Be it resolved that the MMA initiate a study of the merits of a single-payer system with its possible application to the Minnesota health care environment, and that a report, outlining the feasibility of a single-payer system in Minnesota, and its impact on physicians and their patients and including recommendations, be presented to the MMA Board of Trustees for review and possible action prior to the 1995 legislative session.

Res. 27, Support of Patient Protection Act of 1994

Introduced by: RCMS

Be it resolved that the MMA publicly support the Patient Protection Act of 1994, encouraging Minnesota's congressional delegation to secure its passage, and that the MMA actively pursue the inclusion of appropriate provisions of the Patient Protection Act of 1994 in Minnesota state law.

Res. 28, Reporting of Administrative Costs in Health Care Spending

Introduced by: RCMS

Be it resolved that the MMA work with the Data Institute, the Minnesota Department of Health, and other appropriate agencies to develop reporting methods for health care expenditures that will give the public an accurate accounting of where resources are spent in the health care system, including resources spent on administrative services.

Res. 29, Study of the Impact of the $400 Physician License Surcharge on Medicaid Reimbursement

Introduced by: RCMS and HCMS

Be it resolved that the MMA conduct a study to determine if Medicaid reimbursement to physicians has changed, as was promised by the 1992 Legislature, and whether physicians actually recoup their license surcharge, and that the study be conducted with the goal, if possible, of having its final results presented to the MMA Board of Trustees for review and possible action before the 1995 legislative session.

Res. 30, Clarification of the Term "Provider" in Advertising, Contracts, and Other Communications

Introduced by: RCMS

Be it resolved that the MMA develop and support legislation requiring that health care entities when using the term "provider" in contracts, advertising, and other communications, specify the type of provider being referred to by using the provider's recognized title, which details education, training, license status, and other recognized qualifications, and that the MMA take a resolution to the AMA calling for the replacement of the current definition of physician in federal law with the AMA's definition.

Res. 31, Data on Firearm Deaths and Injuries

Introduced by: RCMS

Be it resolved that the MMA work with the Minnesota congressional delegation, as well as bring a resolution to the AMA, encouraging the enactment of the following: 1) the federal government should resume asking questions in the National Health Interview Survey about firearm-related injury as was done prior to 1972; 2) Congress should mandate that the Centers for Disease Control and Prevention develop a national firearm fatality reporting system; and 3) the National Electronic Injury Surveillance System should expand its activities to begin tracking firearm-related injuries.

Res. 32, Standardized 2 Percent Provider Tax Reporting by Third-Party Payers

Introduced by: RCMS

Be it resolved that, until the 2 percent provider tax is repealed, the MMA form a coalition, representing all health care providers, to work with the Legislature, the state revenue commissioner, and third-party

Resolutions continued on page 40

Resolutions *continued from page 39*

payers to develop a consistent format for reporting the 2 percent provider tax that will be used uniformly by all third-party payers when making payments to physicians and other health care providers.

Res. 33, Establishment of Peer Consultation Program to Assist Physicians in Disputes with Health Plans

Introduced by: RCMS

Be it resolved that the MMA establish a peer consultation program to assist physicians involved in disputes with insurance companies or health plans regarding patient treatment decisions.

Res. 34, Student Loan Payment Deferment

Introduced by: RCMS

Be it resolved that the MMA bring to the AMA a resolution supporting the creation of a deferment program for government-sponsored guaranteed student loans that would delay repayment of such loans by medical students until one year after the completion of a residency program.

Res. 35, Repeal of $400 Physician License Surcharge

Introduced by: RCMS

Be it resolved that the MMA restate its opposition to the $400 physician license surcharge and continue its efforts to gain its repeal at both the state and national levels.

Res. 36, Mandated Use of High Efficiency Particulate Air Filter Masks

Introduced by: RCMS

Be it resolved that the MMA work with the Minnesota Hospital Association to protest the current regulation on high efficiency particulate air filter masks as an expensive and unproven safety measure until their efficacy can be proven with appropriate epidemiologic studies.

Res. 37, Radiological Technologist Certification

Introduced by: Minnesota Radiological Society

Be it resolved that the MMA reconsider its stand on radiologic technologist certification and convene a consensus panel made up of representatives of the MMA, the Minnesota Society of Radiologic Technologists, the Minnesota Radiological Society, and the Minnesota Hospital Association charged with the task of developing acceptable legislation regarding radiologic technologist certification to be presented to the next session of the Minnesota Legislature.

Res. 38, Commendation for C. Randall Nelms Jr., M.D.

Introduced by: RCMS

Be it resolved that the MMA commend C. Randall Nelms Jr., M.D., for his outstanding leadership as president of the MMA, and that the MMA extend its sincere appreciation for his leadership, dedication, enthusiasm, and talent in serving as president.

Res. 39, Policy on Handguns and Automatic Repeating Weapons

Introduced by: Public Health and Preventive Medicine Committee

Be it resolved that the MMA adopt as policy the following components of AMA policy related to handguns and automatic repeating weapons: 1) support mandatory destruction of any weapons obtained in local buy-back programs; 2) support legislation outlawing Black Talon and other similarly constructed bullets; 3) support the right of local jurisdictions to enact firearm regulations that are stricter than those in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls; 4) support stricter enforcement of present federal and state gun control legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm; 5) reaffirm or create policy supporting waiting periods and background checks for purchasers of firearms; and 6) reaffirm or create policy supporting legislation restricting the sale and private ownership of large clip, high rate-of-fire automatic and semi-automatic firearms.

Res. 40, Firearm Injury Prevention Task Force Study

Introduced by: Public Health and Preventive Medicine Committee

Be it resolved that the MMA support efforts to expand the scope of the original mortality study conducted by the Firearm Injury Prevention Task Force to include new data (beyond 1988).

Res. 41, Study on Number of Firearms in Schools

Introduced by: Public Health and Preventive Medicine Committee

Be it resolved that the MMA encourage the appropriate state agency to collect data and develop a study on the number of firearms in schools and the use of firearms by Minnesota youth, and that the MMA encourage the state to share the results of such a study with the MMA. • • • • •

The Monitor

SEPTEMBER 1994

• • •

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New Law Avoids Unnecessary Punishment of Impaired Physicians

The 1994 Health Professionals Services Program allows for treatment of impaired health care professionals without imposing a public disciplinary sanction.

Kent G. Harbison, J.D.

Of the approximately 1,200 complaints filed against physicians each year with the Minnesota Board of Medical Practice, about 9 percent involve claims of alcoholism, chemical dependency, mental illness, and other types of "impairments" affecting physicians' practices. The board recognizes that these impairments may pose a potential threat to the safety and welfare of patients and may violate the Minnesota Medical Practices Act, thus justifying disciplinary sanctions against impaired physicians if the impairments affect their ability to practice medicine with reasonable skill and safety. The board also recognizes, however, that impaired physicians suffer from disability or illness, distinguishing their violations from those that arise out of intentional misconduct or carelessness.

In the past, the board has had some difficulty deciding how best to protect the public from an impaired physician without also unnecessarily punishing or disciplining the physician because of a disability. The 1994 Minnesota Legislature, with the urging and support of the Board of Medical Practice (BMP) and other health licensing boards, enacted an amendment to Minnesota law that is aimed at resolving this dilemma. The new law establishes a diversion program allowing the participating licensing boards to provide treatment and to monitor impaired health care professionals without also imposing a public disciplinary sanction. The new law, entitled the "Health Professionals Services Program," is an amendment to Chapter 214 of the Minnesota Statutes. The new law is already in effect, although rules implementing and clarifying it are required to be promulgated by July 1, 1996. The Health Professionals Services Program law applies to health care professionals licensed by the participating boards—so far the boards of medicine, nursing, dentistry, pharmacy, and podiatry.

Before the law's enactment, most physicians who were investigated by the BMP concerning "impairment violations" faced disciplinary orders that imposed extensive and strict conditions on their licenses. Even though these disciplinary orders under the pre-1994 law were not reported by the board to the news media, they were included in the board's public records, which were open to inspection by anyone who cared to review them. The new law replaces the sting of a disciplinary order with a diversion program designed to help physicians overcome impairments without being disciplined and without facing public disclosure.

A Combined Effort

The Health Professionals Services Program is a joint effort by the five participating health regulatory boards listed above (including the BMP). According to the Legislature, the purpose of the new program is to protect the public from physicians and other licensed health care professionals "who are unable to practice with reasonable skill and safety by reason of illness, use of alcohol, drugs, chemicals, or any other materials, or as a result of any mental, physical, or psychological condition." This language is similar to that contained in one section of the Medical Practices Act authorizing the Board of Medical Practice to impose discipline on a physician for these types of impairments. Although the board still retains the authority to discipline a physician for violating the Medical Practices Act, including any of the impairments covered by the new Health Professionals Services Program, there is an assumption that the board will "divert" many impaired physicians to the new program as an alternative to taking disciplinary action. Physicians should understand, however, that the board still has the power to discipline an impaired physician *and* also direct that physician to participate in the new program.

The Health Professionals Services Program basically is a mechanism by which physicians and other health care professionals can receive counseling, treatment, and monitoring of their progress with respect to certain types of illnesses or impairments. The new program will be managed by two different committees, although one of them is only temporary. The program committee, the main committee responsible for the continuing management of the program, is composed of one person appointed by each of the

participating boards.

During the first three years of the program, the program committee will obtain input from an advisory committee composed of representatives from the private health professional associations, including the Minnesota Medical Association, and two public members. The advisory committee, unlike the program committee, does not have any right to vote on program management decisions, but it will provide consulting services and advice to the program committee regarding the management and development of the Health Professionals Services Program and its relationships with the various licensing and regulatory boards. The advisory committee is slated to terminate on June 30, 1997. The MMA and other health associations presumably could offer advice and comment to the program unofficially after that date.

Treatment and Monitoring

Participation in the services program is, to a great extent, voluntary. A physician who is impaired under the definition contained in the new statute may simply apply to obtain treatment in the new program, without contacting the Board of Medical Practice. Also, of course, the board may require an impaired physician to participate in the program as a condition for avoiding disciplinary sanctions or retaining his or her license to practice medicine. (The same scenario would apply with respect to any other health care professionals whose regulatory boards are participating in the program.)

Once physicians are admitted to the program, they are expected to sign a participation agreement tailored to their individual needs. The agreement sets out a plan for evaluation, treatment, and continuing care. It could include monitoring the physician's medical practice, randomly screening for drug use, requiring participation in support groups, restricting the physician's practice, requiring periodic status reports, etc.

Physicians are required to pay their own costs for participating in the program. The new law, however, states that each physician's (or other regulated person's) financial resources must be taken into account in developing the individual agreement and program plan.

The new law excludes six categories of health care professionals from participating in the program. Excluded are those who:

1. have diverted controlled substances for other than self-administration, i.e., persons who have improperly supplied controlled drugs to other persons;
2. have previously been terminated from the program or any other state professional services program because of noncompliance with the program requirements;
3. are currently under a disciplinary order or corrective action agreement from one of the regulatory boards, unless that board refers the health care professional to the program;
4. are regulated under other Minnesota laws pertaining to persons who have tested positive for HIV/HBV, unless that person is referred to the program by one of the regulatory boards or the Minnesota commissioner of health;
5. have been accused of sexual misconduct (suggesting that the mere allegation, rather than a finding of liability or guilt, is enough to exclude someone from the program); and
6. "would create a serious risk of harm to the public" if they continued to practice. (The statute does not define what constitutes serious risk of harm to the public, but perhaps the forthcoming program rules will address this issue.)

A physician who participates in the program can leave it in one of three ways. First, participation ends when the physician successfully completes the program. Second, a physician may voluntarily terminate his or her participation in the program at any time for any reason or for no reason. Under these circumstances, however, the terminating physician is required to report his or her illness or impairment to the Board of Medical Practice, which would likely investigate the matter to determine whether discipline is required or whether the physician should be ordered to return to the program. Third, the program manager may expel a physician for any reason, for example, if the physician is not complying with the program requirements or if necessary medical records or other information deemed critical to successful completion of the program are not obtainable. The manager's decision to discharge a physician from the program must be reported to the BMP, which still has the authority to require the physician to return to the program as a condition for retaining his or her license.

A Non-Disciplinary Option

The program manager must report to the Board of Medical Practice any physician who applies to participate in the program but does not meet the admission criteria. These criteria apparently are those described in the six statutory categories of persons not eligible to participate in the program, and they may in the future be clarified by formal rules. The new law also requires program managers to report to the board any physician "who is alleged to have committed violations" of the Medical Practices Act that are beyond the scope of the Health Professionals Services Program. This suggests that if a physician is admitted to the program because of any mental, physical, or psychological impairment, and the program manager subsequently learns that the same physician also is *alleged* to have had inappropriate sexual contact with patients, violated normal prescribing practice standards, or committed other violations of the Medical Practices Act, the program manager is compelled to report these other allegations to the Board of Medical Practice.

Although the board still has the authority to impose discipline against a physician whose impairment is deemed to violate the Medical Practices Act, it is more likely that the board will use the Health Professionals Services Program instead of disciplinary sanctions as a method for dealing with impaired physicians.

Some impaired physicians, however, may not totally escape public discipline. The board may still discipline an impaired physician if there is evidence of a different and unrelated violation of the Medical Practices

Act, such as fraudulent billing practices. Furthermore, even if there is no other type of misconduct alleged, the board may choose not to divert a physician to the new program in certain circumstances.

New Reporting Requirement

Physicians have often been concerned in a broader sense about the legal requirements to report themselves or their colleagues to the BMP because of possible or alleged violations of the Medical Practices Act. In fact, physicians with "personal knowledge" of such violations run the risk of being disciplined themselves for not reporting the information to the board. (There is a limited exception to this reporting requirement for physicians who gain the personal knowledge of a violation through the physician-patient relationship when the patient is the reportable physician.) The new law does not change these reporting requirements significantly. It does, however, set up a two-pronged reporting procedure.

First, any person who has personal knowledge that a physician is unable to practice "with reasonable skill and safety" because of one of the illnesses or conditions described in the new law has the option to file a report either with the Health Professionals Services Program *or* with the Board of Medical Practice. The 1994 law also provides that any report made under this section of the law satisfies the reporting requirements contained in other laws regulating the reporting person's profession.

A question might arise out of the relationship between the reporting requirement under the 1994 law and the reporting requirements contained in other laws regulating health care professionals, such as the Minnesota Medical Practices Act. The 1994 law suggests that a physician *may* file a report concerning another physician's impairment with either the board or the new program. Does this mean that a physician with personal knowledge of another physician's impairment is free *not* to file a report with either the program or the medical board? The answer is probably no. The Board of Medical Practice is likely to take the position that the only discretion a physician has in deciding whether to report another physician is to decide whether the report should go to the Board of Medical Practice or to the new program. Failure to report such information will probably be considered a violation of the Medical Practices Act and, therefore, a potential basis for disciplinary action against the non-reporting physician.

The second reporting requirement under the new law is much clearer. It specifically states that a physician suffering from an illness or condition that precludes the practice of medicine with reasonable skill and safety *must* report himself or herself either to the board or the new program. Since the Medical Practices Act also compels self-reporting regarding any violation of the act, a failure to self-report probably would be considered grounds for disciplinary action.

Immunity from Liability

Many physicians feel uneasy about reporting a colleague to a regulatory agency or governmental program. Failure to make such reports, however, puts the non-reporting physician at risk of a disciplinary proceeding. On the other hand, physicians who do file reports sometimes are concerned about being sued or subjected to other legal proceedings commenced by the person reported. This concern should be greatly alleviated under both the Medical Practices Act and the new Health Professionals Services Program law. As in the past, all reports are required to be kept confidential and privileged. And perhaps more important, the 1994 law establishing the diversion program provides that any individual or entity who submits a report "in good faith" to the program or otherwise cooperates with an investigation of such a report is immune from civil liability or criminal prosecution. The Medical Practices Act provides similar immunity protection for persons or entities filing reports to the board for any alleged violation of the Medical Practices Act.

Under both the 1994 law and the Medical Practices Act, all members of the Board of Medical Practice and other licensing boards (and their consultants and advisory bodies) are also immune from civil liability or criminal prosecution for "any actions, transactions, or reports in the execution of, or relating to, their duties" under the law.

No Public Disclosure

The BMP, unlike other health licensing boards, is required by law to disclose affirmatively its disciplinary decisions to the news media. Even the Medical Practices Act, however, makes an exception for disciplinary decisions regarding a physician who is suffering from an illness or impairment affecting his or her ability to practice medicine. Disciplinary decisions based on this factor become part of the board's public record, but they are not distributed to the news media or other entities.

Under the new Health Professionals Services Program, physicians should not have any concern about public disclosure of their participation in the program. The 1994 law provides that all information collected by the program concerning any physician, including the agreements between the physician and program, are not public records. In fact, the information and participating agreements are not even permitted to be disclosed to the licensing boards, unless the program reports a regulated person to the appropriate board because of that person's ineligibility or termination from the program.

The Board of Medical Practice has been designated as the licensing board providing the primary administrative management services for the new program. Ideally, the Health Professionals Services Program will enable the board to deal with impaired physicians more easily and appropriately outside the traditional disciplinary process. And the board hopes the new diversion program will reduce the substantial backlog of complaints it processes annually. By recognizing that physicians suffering from physical, mental, or other impairments should not ordinarily be disciplined because of their disabilities, the board may now be able to remove a substantial category of complaints from its disciplinary system.

continued

Meanwhile, the impaired physicians will be in a better position to receive prompt diagnosis and treatment that might enable them to continue practicing medicine safely without the threat of public stigma. MM

Kent Harbison is an officer and shareholder at Fredrikson & Byron and works in the firm's Litigation Department, handling a variety of general commercial, health law, banking, probate, and employment cases.

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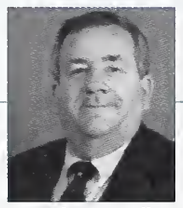
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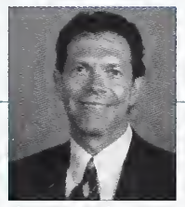
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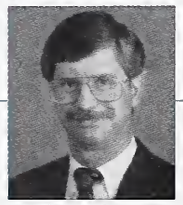
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SMITH

(continued from page 7)

year-old Smith began his involvement with the MMA by serving on and then chairing the Communications Committee.

Since 1982, Smith has chaired and served on numerous MMA committees and task forces, focusing on issues ranging from workers' compensation to professional liability and risk management, to policy implementation and rural health, to MinnesotaCare and long-range planning. He chaired the MMA Board of Trustees from 1990 to 1993 before running for president-elect last year.

Apart from the MMA, Smith chairs Medical Alley's Task Force on Cost Effectiveness, through which he is involved in the increasingly important issue of resource allocation, evaluating the cost-effectiveness of medical technology. He has held the presidency of the Minnesota Neurosurgical Society, is a member of the board of trustees of the Hennepin County Medical Society, and serves as an alternate member on the Minnesota Health Care Commission. Nationally, he has held positions with both the American Medical Association and the American Hospital Association. In addition, he has held a number of leadership positions at Methodist Hospital and North Memorial Medical Center, including medical staff president at Methodist.

Smith, a Houston native, received both his bachelor's (mathematics) and master's (mathematics and physiology) degrees from the University of Texas at Austin before earning his M.D. from the University of Texas Southwestern Medical School in Dallas. He carried out his military service as a staff associate at the National Institutes of Health. He then completed his neurosurgical residency and a Ph.D. degree at the University of Minnesota.

Smith's ease with public speaking will serve him well in his new role as MMA president, where he will maintain a visible role as spokesperson and will travel statewide, meeting with both physicians and outside groups in metropolitan and rural areas. Smith says he looks forward to working with physicians around the state to help them redesign and rebuild systems and networks.

"As we restructure," says Smith, "it's important to make sure we're not losing sight of the health care values we hold to be most dear: the primacy of the doctor-patient relationship; the need to move as quickly as possible toward universal access and coverage; the ability of patients to choose their physician, as well as the ability of physicians to choose the type of practice they want; the need for continuity of care; and last, but certainly not least, the importance of medical education and research."

Smith says the MMA plays a vital role in preserving these values, not only by serving its members, but by focusing on public health issues that affect the entire community. He cites MMA's anti-violence and anti-smoking campaigns, as well as programs of the Minority Affairs Committee, as just a few examples of the MMA's responsiveness to community needs.

"I am personally interested in these issues that demand our ongoing attention and am proud of the leadership role the MMA has taken in improving the health status of our population," says Smith. "The MMA has won awards for its programs that benefit the people of Minnesota and, as president, I plan to be involved in this aspect of serving our greater constituency."

Smith is not the only one in his family who believes it is important to give back to the community. His wife, Mary, serves on the Metropolitan Council, dealing with issues of transportation and the infrastructure of the greater Twin Cities area. She is currently running for Hennepin County commissioner.

When they're not working on behalf of the community, the Smiths, who live in Wayzata, enjoy spending time with their three children: Emily, a recent college graduate in architecture; Andrew, a medical student; and Bradley, a high school senior. Smith loves to point to his son Andrew when skeptics ask him about the prognosis for physicians: "Let any of those who think that people in organized medicine are telling their children not to enter their profession know that is clearly not happening. Not only do I have a son in medical school, but the past two MMA presidents have kids in or just out of medical school.

"I believe that the practice of medicine will always be rewarding, and, if we build systems that serve us and our patients better and allow us to have a say in how managed care works, I think there will always be opportunities for young physicians. When it comes down to it," he says, "physicians get most excited about taking care of patients with as little external hassle as possible. I can envision a system that may be very different from the one in which I have practiced for the last 20 years but in many ways would be much more efficient and would allow physicians to get back to basics."

Smith hopes that his MMA presidency will be known for its success in helping to create that system. MM

Fran Miller Toubin is a frequent contributor and free-lance writer living in Minneapolis.

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The Push for National Medical Liability Reform

C. Randall Nelms Jr., M.D.

Physicians can agree on at least one aspect of health system reform: This nation's system for handling medical liability lawsuits is a mess. Without true medical liability reform, health system reform is just a mirage.

The Clinton administration and Congress (in their efforts to construct a comprehensive, but cost-effective national health system reform plan) have it in their power to remove the fastest growing component of health care costs, increase access to medical services, eliminate much of the need for medically unnecessary treatment, improve the patient-doctor relationship, and help prevent avoidable patient injury. National medical liability reform could bring this about, but the trial lawyers' lobby and self-styled "consumer" groups who follow their lead are impeding the progress of such reform. Making matters worse, many lawmakers are floundering on tort reform. The good news is that physicians are no longer alone in pushing to include long-needed reform of the legal system in broader reform legislation.

The Health Care Liability Alliance was established as the national advocate of health system liability reform. Its mission is to achieve enactment of effective health system liability reforms, and, specifically, to see that such reforms are included in whatever national health system reform legislation is enacted. The Health Care Liability Alliance represents a diverse membership of large and small manufacturing and service businesses, health care providers (including the American Medical Association), blood service providers, makers and distributors of health care products, and their insurers. They are united in their commitment to bring greater efficiency, fairness, and predictability to the process by which patients are compensated in cases of medical liability.

"Many lawmakers are floundering on tort reform."

AMA member surveys show that 95 percent of physicians rank effective liability reform as their top priority for health system reform. In addition, 71 percent of physicians say they would oppose any health system reform bill that did not include a limit on damages for pain and suffering.

The United States has the world's most expensive tort system. At 2.3 percent of the gross domestic product, U.S. tort costs are higher than those of any other country. The U.S. tort system cost $132 billion in 1992, including insured and self-insured costs. Between 1933 and 1991, U.S. tort costs rose by a factor of almost 400. Over the past 58 years, tort costs in the United States have grown almost four times faster than the economy.

Despite this magnitude of spending, our tort system fares poorly in meeting its compensation objectives. Only 43 cents of the premium dollar are retained by patients as compensation. The remaining 57 cents go primarily to attorney fees. Studies consistently show that most claims filed have no merit and that many claims with merit never are filed at all. According to the Government Accounting Office, 43 percent of insurance defense costs are spent on claims that have no merit.

The MMA is among the many groups attempting to address these problems. It has 10 principles for medical liability reform: 1) Put reasonable limits on attorney contingency fees with a sliding-scale approach. 2) Expand the collateral sources that may be considered when an award is determined. 3) Strengthen laws that require a plaintiff's attorney to certify that a claim has merit. 4) Emphasize stronger language in the reform passed in the original HealthRight law that provides an absolute defense for providers who follow the commissioner of health-approved practice parameters. 5) Allow, by law, the same access to a physician for defense and plaintiffs' attorneys in a malpractice action. 6) Limit liability of each defendant to the amount of damages allocated to each; if the plaintiff is more at fault than the defendant, there should be no recovery. 7) Put a reasonable cap on damages for pain and suffering by limiting non-economic awards to $250,000. 8) Implement a voluntary dispute resolution program. 9) Establish reasonable periodic payment awards for future damages awarded in a malpractice action. 10) Grant malpractice immunity to physicians and other health professionals who volunteer their services to the community, except in instances of gross negligence.

Reform of our tort system is good for patients, providers, and society. It's time to reform the system and rein in medical liability costs. MM

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People and Places Making Medical News

People

Blue Cross Vice President

Blue Cross and Blue Shield of Minnesota has promoted **Mark Banks, M.D.**, to group vice president. Banks, who was most recently a senior vice president of BCBSM, heads the company's recently created network management division, which encompasses all BCBSM provider network development and management activities, as well as its new strategic partnerships with providers throughout the state. Banks also serves as president and CEO of BCBSM's HMO affiliate, Blue Plus. He began his career with BCBSM in 1986 as vice president and medical director for Blue Plus.

Ophthalmology President

Rene W. Pelletier, M.D., of St. Paul, has succeeded **Theodore L. Fritsche, M.D.**, as president of the Minnesota Academy of Ophthalmology. Pelletier, an ophthalmologist with the St. Paul Eye Clinic, will hold office through July 1995.

Also taking office are **Paul E. Wicklund, M.D.**, of Wayzata, president-elect; **Jo Ann Reed, M.D.**, of Minneapolis, secretary; and **Edward J. Holland, M.D.**, of Minneapolis, treasurer.

Fairview Chief of Staff

Alfred E. Lounsbury, M.D., has been named chief of staff at Fairview Ridges Hospital. He practices internal medicine at Oxboro Clinic and has been on staff at the Fairview Ridges Hospital for the past seven years. Before joining Oxboro Clinics, Lounsbury was affiliated with Park Nicollet Medical Center in Burnsville. He will serve a one-year term.

AHA Chair-Elect

The American Hospital Association's House of Delegates has elected **Gordon M. Sprenger** chair-elect designate. Sprenger, executive officer of Allina Health System of Minneapolis, begins his duties January 1, 1995, and will become chair of AHA's board of trustees the following year. He will succeed Gail Warden, president and chief executive officer of Henry Ford Health Systems in Detroit.

Sprenger's duties as chair-elect will include presiding over AHA's Strategic Planning Committee, which identifies the association's priority initiatives, and Hearing Committee, an open forum for any AHA member wishing to express an opinion on an association issue.

Fairview Riverside Officers

Connie Weinman has been elected chair of the Fairview Riverside Medical Center board of trustees. Weinman, a Roseville resident, is vice president and compliance counsel for National City Bank and has served on the Fairview Riverside board since 1979.

Other officers are **William Hedrick, M.D.**, vice chair, an internal medicine specialist, and **Allen Housch**, secretary and treasurer, president of A.A. Housch.

Places

Mayo and 'U' Hospital Among Top

The Mayo Clinic and the University of Minnesota Hospital are rated among the nation's top hospitals in the annual guide "America's Best Hospitals," published in *U.S. News and World Report* in July. The ratings are compiled based on the opinions of randomly selected doctors in 16 medical specialties and on a combination of nine quality indicators. Of 13 hospitals that rated in the top 10 for at least four of the 16 specialties, Mayo was second only to Johns Hopkins in Baltimore. UCLA Medical Center in Los Angeles was third, followed by Massachusetts General Hospital in Boston, Duke University Medical Center in Durham, North Carolina, and the Cleveland Clinic. Hopkins was in the top 10 of 15 specialties; Mayo was in 14.

U.S. News rated Mayo first in cardiology, endocrinology, gastroenterology, urology, and neurology; second in gynecology, orthopedics, and rheumatology; fourth in cancer; sixth in otolaryngology and rehabilitation; ninth in geriatrics; and 10th in psychiatry and AIDS treatment.

The University of Minnesota ranked 15th in endocrinology, 18th in gerontology, 20th in otolaryngology, 25th in urology, 27th in gastroenterology and rheumatology, 29th in neurology, 33rd in AIDS, 35th in cancer, 38th in orthopedics, and 41st in cardiology.

Mayo Serving Prairie Island

Mayo Clinic family medicine specialists now provide basic health care services to members of the Prairie Island Dakota Community at its Community Health Clinic near Welch, Minnesota. Mayo physicians travel two half-days per week to Prairie Island and work in cooperation with a licensed practical nurse and community health workers from the Prairie Island Dakota Community who staff the clinic Monday through Thursday. Prairie Island Dakota Community members have special phone access to Mayo family medicine specialists on evenings and weekends for urgent health care needs.

The clinic will diagnose and treat common medical problems and prescribe medications. Patients who need laboratory and x-ray services may have the procedures performed at Mayo in Rochester. Members of the Prairie Island Dakota Community will also have

access to patient education services and the option of participating in some of Mayo's research studies.

Mayo Joins Research Group

The Mayo Comprehensive Cancer Center has joined the Gynecology Oncology Group, a national network of health care organizations that offers gynecologic cancer patients investigational clinical research trials. Harry J. Long, M.D., a Mayo oncologist and organizer of the initiative, says that joining the network will offer Mayo gynecologic cancer patients access to more research studies than were previously available. He says the majority of clinical research studies offered will be for ovarian and cervical cancer patients, but many will be for patients with endometrial cancers, vulvar cancers, or uterine sarcomas. Mayo will choose which studies to participate in, focusing on the types of gynecologic cancers it treats the most. In addition, it will offer studies for patients with rare forms of cancer by combining efforts with other institutions.

Mayo Starting New Allied Practitioner Programs

Mayo Clinic is working with two area universities to start new programs for mid-level practitioners in health care. Mayo will link up with the University of Wisconsin-LaCrosse in partnership with Gundersen Clinic of La Crosse to open a physician assistant baccalaureate degree program at UW-L beginning in September 1995 with a class of 12 students. Mayo is also involved in a master's degree adult nurse practitioner program, which begins this month at Winona State University-Rochester Center. Nurse practitioner and physician assistant students will go to Mayo for lectures and clinical rotations as part of their new programs.

BirthPartners Clinic Opens

Fairview Riverside Medical Center, Seton Outreach Services for Women and Families, and the Riverside University Family Practice Clinic (formerly Smiley's Point Clinic) have opened BirthPartners, a clinic for single pregnant women and low-income families. The new clinic, located within the Riverside University Family Practice Clinic at 2615 East Franklin Avenue in Minneapolis, provides medical prenatal care, counseling and support groups, childbirth education classes, nutrition counseling, and postpartum checkups.

Socioeconomics

HealthSpan Merger Approved

Minnesota Commissioner of Health Mary Jo O'Brien approved in late July HealthSpan's application for antitrust exception. The process protects the merger of Health One and LifeSpan hospital chains (which resulted in the creation of HealthSpan in March 1993) from potential federal and state antitrust liability.

The commissioner's review concluded that the merger would result in cost savings in excess of $31 million. She found that competition assisted by regulation will pass through the large majority of these savings to purchasers of hospital services.

The commissioner will supervise and monitor the arrangement, and HealthSpan is required to meet specified hospital revenue growth limits to assure that cost savings are passed on to purchasers of services. The revenue growth limits must be applied to all of the HealthSpan hospitals and are more stringent than the limits set by MinnesotaCare. The commissioner will also collect information from HealthSpan on quality of care, including measures of patient outcomes and patient satisfaction. Then, in 1995, the commissioner will review the arrangement to determine whether additional regulation is needed in 1996.

The antitrust exception process was established as part of the 1993 MinnesotaCare law, which created an opportunity for the state to review proposed arrangements and to provide immunity from antitrust liability when an arrangement is likely to result in lower costs, greater access, or better quality than would otherwise occur in the marketplace.

HealthSpan, Medica Complete Merger

Days after HealthSpan's antitrust exception application was approved, Medica and HealthSpan completed their merger first announced last December. The new nonprofit integrated health care system, known as Allina, includes 17 hospitals, more than 40 clinics, a home health care company, the Select Care doctor network, and three Medica health plans with 580,000 members.

Leadership for the new organization will come from an executive office consisting of Gordon Sprenger, executive officer, and K. James Ehlen, M.D., president, and from a board of directors. Sprenger will have responsibility for the company's finance, administration, planning, and support functions. As president, Ehlen will be responsible for Allina's integrated service network, managed care products, hospitals and other delivery sites, and its physician organizations and professional provider relations.

John Grotting will lead Allina's Delivery Services Group, one of three business groups within Allina. He will have responsibility for Allina hospitals and nursing homes, as well as the system's medical transportation, home health care, and health-related services. John Kleinman, M.D., will lead the Professional Services Group, which will include Allina's group practice organization, physician support services, and medical policy functions. David Strand will head Allina's Health Plans Group and will be responsible for the managed care component of Allina.

Shortly after the Allina merger,

the company signed a letter of intent with StrategiCare, Inc., that when finalized will grant Allina a controlling interest in the Twin Cities-based developer and provider of medical practice management systems and administrative services. Under terms of the agreement, Allina will acquire 80 percent equity interest in StrategiCare, the parent company of DISC Computer Systems, Inc., and Marudas Business Forms Company. A third subsidiary, which provides consulting, personnel placement, and other management services to health care providers, will not be part of the acquisition and will operate independently.

Fairmont Clinic, Mayo to Affiliate

Mayo Clinic has announced plans to affiliate with Fairmont Medical Clinic, a 16-physician clinic that provides both family practice and specialized services through offices in Fairmont, Minnesota, and Armstrong, Iowa. The Fairmont Medical Clinic will continue to provide primary and specialized health care services to patients in Fairmont and the surrounding area. Its physicians and employees will become part of Mayo's physician and allied health staff, and the clinic—to be called the Fairmont Clinic—will become part of the Mayo Health System. Fairmont Clinic patients are expected to see few changes in how their health care needs are met. Mayo will be one option for specialized care, but not the only option.

HMO Links Pay Increases to Quality Care

HealthPartners has notified some of its doctors and other employees that compensation increases for 1995 will be based on the organization meeting certain performance criteria. The key areas it will consider include customer service, care outcomes, member satisfaction, and financial performance. The staff affected will include Group Health doctors and management. About 600 of HealthPartners' employees, or about 10 percent, will be affected, according to Sara McFee, HealthPartners' spokesperson.

Prudential Ending Health Plan

Prudential Insurance Co. has decided to discontinue its Prudential Plus of Minnesota Plan because of tough competition in the Twin Cities. About 30,000 members will have to find new coverage by December 1995, and about 80 metro-area jobs will be cut. Prudential is the group that won the Employers Association's managed care bid two years ago to provide health care coverage at group rates for member employers (small and medium-sized businesses).

Prudential has managed care plans in 42 cities, but only the Twin Cities has posed a problem, said company officials. "Recent mergers, acquisitions, and strategic alliances involving health care plans and providers and the resulting business climate have combined to make it increasingly difficult to compete in this marketplace," said Gary Schulz, executive director of Prudential Plus of Minnesota, in a Minneapolis-based *Star Tribune* article.

Prudential will continue to offer group products such as disability, managed dental, and administrative services through a local marketing office in the Twin Cities.

Rates, Trends, Data

Minnesotans Think Casinos Should Help Fight Addiction

Eighty-two percent of Minnesotans responding to a Star Tribune/WCCO-TV poll believe casinos should be required to contribute part of their profits to treatment of compulsive gamblers, while only 40 percent believe health insurance companies should cover such treatment. The 17 Indian-owned casinos in Minnesota voluntarily contributed about $240,000 to various treatment programs for problem gamblers last year, but they are not required to make such contributions. The state lottery is required to contribute 2 percent of net proceeds to gambling treatment and research.

The poll also showed that 68 percent of respondents believe insurance companies should be required to cover treatment for alcoholism, and 70 percent believe they should cover treatment for drug addiction. About half say insurance should cover eating disorders and sexual addictions. Meanwhile, only about 40 percent say tobacco addiction and compulsive gambling should be covered.

Medical Research

Marketing of Epilepsy Drug Halted

Marketing of the anti-epileptic medication Felbatol has been halted worldwide because of life-threatening problems with its use, according to the U.S. Food and Drug Administration and Carter Wallace Inc. Development of an unexpected side effect, aplastic anemia, has been cited in 10 of the nearly 100,000 patients using the medication worldwide. Two subsequent deaths from aplastic anemia have been reported since the drug came on the market one year ago.

Robert J. Gumnit, M.D., president of MINCEP® Epilepsy Care, warned that patients should not discontinue their use of the drug without talking to their physicians. "The risk of seizures or death due to stopping such a medication abruptly is much, much greater than the threat of aplastic anemia," he said. FDA officials contacted Gumnit, who is also president of the National Association of Epilepsy Centers, and his MINCEP® colleague, Ilo E. Leppik, M.D., president of the American Epilepsy Society, to ask them to help notify physicians and patients about the drug's side effect. Epilepsy Care physicians are available at 612/525-2400 to answer questions about the ongoing use of Felbatol.

Eating Fish May Reduce Smokers' Risk of Chronic Lung Disease

Consuming fish may help smokers avoid chronic lung disease, according to a study by University of Minnesota researchers published in the July 28 *New England Journal of Medicine*. Smokers who ate fish frequently were significantly less likely to suffer emphysema and bronchitis than smokers who ate less fish, but the researchers noted that more research is needed to determine whether fish actually prevent lung disease in smokers.

The study, based on a questionnaire of 8,960 current and former smokers, compared those who ate fish an average four times a week with those who had it only once every two weeks. Those who ate more fish had a one-third lower risk of bronchitis and a two-thirds lower risk of emphysema. The authors theorize that fish oil may inhibit inflammation in the lungs.

Mayo Begins First Gene Therapy Study for Colon Cancer

Mayo Clinic researchers have begun the first direct gene therapy Phase I clinical study in the United States for colon cancer patients. Similar gene therapy studies are in progress at the University of Chicago for kidney cancer and at the University of Arizona for malignant melanoma.

In the Mayo study, researchers inject the drug Allovectin-7, manufactured by Vical Inc. of San Diego, California, into a patient's cancerous tumor. The drug contains a gene that is expected to be taken up by the tumor cells and cause them to produce a foreign antigen. Since the human body has cells that fight foreign material, researchers are optimistic that the body's natural immune system will recognize the new antigen as a foreign substance and destroy the tumor.

The new procedure is being tested with 15 patients who have colon cancer that has spread to the liver. Patients must have at least two tumors in the liver to allow researchers to compare the genetically altered tumor with other untreated tumors. Researchers will monitor patients closely to see if the treated tumor has shrunk or disappeared and to see if other untreated tumors have responded.

NAS to Investigate Chemical Spraying in Minneapolis

Congress has agreed to appropriate money for the National Academy of Sciences to study the effects of chemical spraying 40 years ago by the U.S. Army in Minneapolis and other cities nationwide. The Army sprayed 17.1 pounds of zinc cadmium sulfide, a carcinogen, in various Minneapolis neighborhoods during the winter and summer of 1953 to test how chemical weapons disperse in different weather. The Army had the city's permission, but the general public was not informed.

The U.S. Army conducted its own study and said no adverse effects occurred because of the spraying, but "people want an independent study," said Sen. Paul Wellstone at a news conference. The study should begin in October and last 18 months

AIDS Update

Gay Teens Not Avoiding Risk

Gay and bisexual teens are well-informed about AIDS, but they are not making great efforts to protect themselves from the disease, according to a University of Minnesota study published in the August *Pediatrics*.

In a test to gauge AIDS knowledge, gay and bisexual teens scored an average of 91 percent. But despite their knowledge, 63 percent of the 239 study participants were at "extreme risk" of having been exposed to HIV because of unsafe sex or shared needles.

In Minnesota, about two-thirds of the 2,000 AIDS cases have occurred in young men between the ages of 13 and 21 who have had sex with other young men, said the study's author, Gary Remafedi, M.D. MM

Corrections

Ramsey's Burn Center

An August "News Clip" reported information from a St. Paul-Ramsey press release that inaccurately described the medical center's new burn center. According to the correction issued by Ramsey, the burn center will be an 18-bed, not 24-bed, unit. The center is expected to treat approximately 200 inpatients and 1,500 outpatients annually, and it will be twice the size of the current center, not three times as large, as previously reported.

Minneapolis Children's Medical Center

A July "News Clip" erroneously reported that actions taken by Gov. Arne Carlson to delay cuts in Medicaid funding might have prevented employee layoffs at Minneapolis Children's Medical Center. To clarify, Carlson's delay of Medicaid funding cuts is related to the hospital peer grouping issue, not the Medicaid rebasing issue that affected Minneapolis Children's to a much greater extent. Carlson's action does not change the impact of Medicaid rebasing on Minneapolis Children's.

New Shakopee Medical Campus

A July "News Clip" describing construction of a new medical campus in Shakopee should have said the campus will include a new St. Francis hospital, a new Park Nicollet Shakopee clinic, and a medical office building. St. Francis Regional Medical Center, Park Nicollet Medical Center, HealthSpan Health Systems Corporation, and Benedictine Health System announced the preliminary agreement in May.

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

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Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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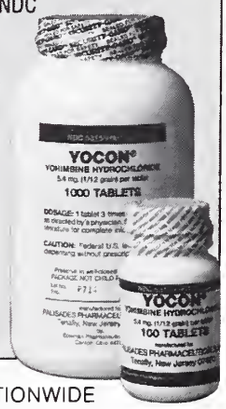

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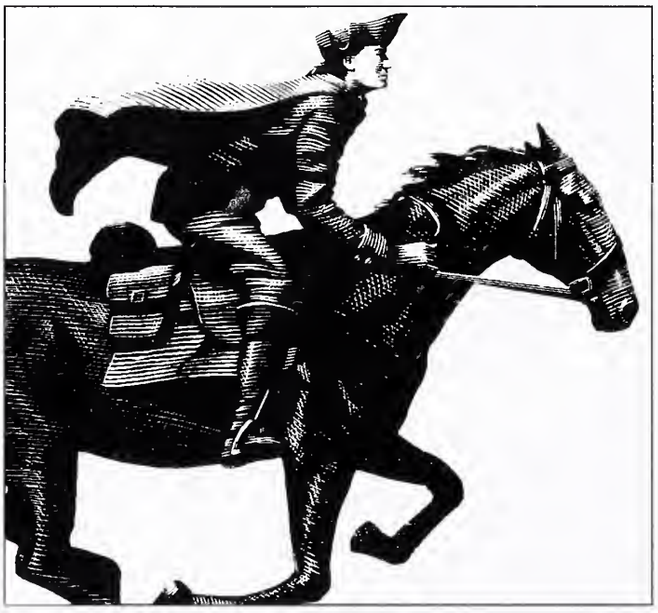

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SEPTEMBER 1994

Sept. 9 **Minnesota Disaster and Hazardous Materials Management** Hennepin County Medical Center and the University of Minnesota; Saint Cloud Civic Center, Saint Cloud, MN. CONTACT: Ann Samways, CME Coordinator, HCMC/HFA Office of Academic Affairs, 701 Park Avenue South, Mail Code 869A, Minneapolis, MN 55415-1829; 612/347-2078.

Sept. 12-13 **Pediatric Emergency Medicine Course** HealthSpan; United and Children's Hospital Conference Center, St. Paul, MN. CONTACT: Annette Carlson, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7910.

Sept. 12-14 **The Norwegian-American Orthopaedic Society** Mayo Foundation; Siebens Medical Education Building, Rochester, MN. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME and International Education, 200 First Street SW, Rochester, MN 55905; 507/284-2509.

Sept. 12-16 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.

Sept. 15-17 **Practical Surgical Pathology** Mayo Medical Laboratories; Harold W. Siebens Building, Rochester, MN. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Sept. 22-23 **Fourth Annual Practical Pediatrics for the Primary Care Physician** Children's Hospital of St. Paul; Children's Hospital, St. Paul, MN. CONTACT: Mickey Starr or Janet Salmey, 345 North Smith Avenue, St. Paul, MN 55102; 612/220-6109.

Sept. 23 **Contemporary Issues in Hemodialysis** Hennepin County Medical Center/Hennepin Faculty Associates Office of Academic Affairs and University of Minnesota; Sheraton Midway Hotel, St. Paul, MN. CONTACT: Ann Samways, CME Coordinator, 612/347-2078; or Robin Hoppenrath, Manager, Office of Academic Affairs, 612/337-7128.

Sept. 23-24 **The Lower Extremity Amputee: A Multidisciplinary Approach** Mayo Foundation; Mayo Foundation, Rochester, MN. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 23-25 **Annual Ambulance Medical Directors Retreat** Hennepin County Medical Center/Hennepin Faculty Associates Office of Academic Affairs and University of Minnesota; Arrowwood Resort, Alexandria, MN. CONTACT: Ann Samways, CME Coordinator, 612/347-2078; or Robin Hoppenrath, Manager, Office of Academic Affairs, 612/337-7128.

Sept. 29-30 **Basic Colposcopy** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Sept. 30 **Annual Focus on the Kidney in Primary Care** University of Minnesota and Hennepin County Medical Center; Sheraton Park Place, Minneapolis, MN. CONTACT: Ann Samways, CME Coordinator, HCMC/HFA Office of Academic Affairs, 701 Park Avenue South, Mail Code 869A, Minneapolis, MN 55415-1829; 612/347-2078.

Sept. 30-Oct. 1 **Primary Care of Patients with Epilepsy** HealthSpan; United and Children's Hospital Conference Center, St. Paul, MN. CONTACT: Annette Carlson, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7910.

Sept. 30-Oct.1 **Pelviscopic Surgery Including Hysterectomy** HealthSpan; Abbott Northwestern Hospital, Minneapolis, MN. CONTACT: Don Young, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

OCTOBER 1994

Oct. 1 **Interventional Radiology** HealthSpan; Grand Hotel, Bloomington, MN. CONTACT: Don Young, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

Oct. 6-7 **Annual Forensic Science Seminar** Hennepin County Medical Center/Hennepin Faculty Associates Office of Academic Affairs and University of Minnesota; Pillsbury Auditorium, Hennepin County Medical Center, Minneapolis, MN. CONTACT: Gail Kraemer, 612/347-2075, Ext. 2125.

Oct. 6-7 **Advanced Pediatric Life Support** Hennepin County Medical Center; Hennepin County Medical Center, Minneapolis, MN. CONTACT: Rachel Knudson, R.N., EMS Training, Hennepin County Medical Center, 701 Park Avenue South, Minneapolis, MN 55415; 612/347-3638.

Oct. 6-7 **Primary Care Emergencies** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

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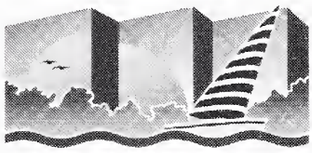

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Oct. 7 **Glaucoma Course** HealthSpan; Phillips Eye Institute, Minneapolis, MN. CONTACT: Michelle Hemingway, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/336-5061.

Oct. 7-8 **Family Practice Update** Hennepin County Medical Center/Hennepin Faculty Associates Office of Academic Affairs and University of Minnesota; Mall of America Grand Hotel, Bloomington, MN. CONTACT: Ann Samways, CME Coordinator, 612/347-2078; or Robin Hoppenrath, Manager, Office of Academic Affairs, 612/337-7128.

Oct. 8 **Current Trends in Ophthalmology** HealthSpan; Hotel Sofitel, Bloomington, MN. CONTACT: Michelle Hemingway, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/336-5061.

Oct. 12-15 **Thoracic Organ Transplantation** Minneapolis Heart Institute Foundation; Westin La Paloma, Tucson, AZ. CONTACT: Don Young, 2810 57th Avenue North, Minneapolis, MN 55430; 612/574-7982.

Oct. 13-15 **Annual Orthopedic and Trauma Seminar** Hennepin County Medical Center/Hennepin Faculty Associates Office of Academic Affairs and University of Minnesota; Pillsbury Auditorium, HCMC. CONTACT: Laura Carroll in Orthopedics, Hennepin County Medical Center, 612/347-2075, Ext. 3736.

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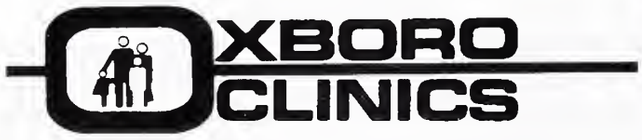

Contact: Physician Placement Office
Fairview Clinic Services
600 West 98th Street, Suite 390
Bloomington, MN 55420
(612) 885-6224 or toll free **1-800-842-6469**

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DIRECTOR OF CLINICAL SERVICES to join expanding Women's Health Center and Section of General Internal Medicine at University of Minnesota affiliated teaching hospital. Major duties will include patient care, administration of clinical services and teaching of medical students and residents. Advanced training/experience in Women's Health and medical teaching required. Send inquiries and CV to:

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Health Center, (111M)
VA Medical Center
One Veterans Drive
Minneapolis, MN 55417
612/725-2035

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November 10-12	Strategies in Primary Care Medicine, St. Paul
November 17-18	Breaking the Cycle of Violence, Bloomington
December 1-3	Cardiopulmonary Medicine, St. Paul

1995

February 10	Burn Care Today, St. Paul
March 9-10	Family Medicine Today, St. Paul
March 17	Occupational Medicine Update, St. Paul
March 30-31	Critical Care 1995: Practical Approaches & Case Discussions, St. Paul
April 6-7	Obstetrics & Gynecology Update, St. Paul
April 7	ENT Update, St. Paul

Information and registration:
Continuing Medical Education, St. Paul - Ramsey Medical Center,
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- ANNUAL FOCUS ON THE KIDNEY
  September 30
  Sheraton Park Place, Minneapolis
- ANNUAL FORENSIC SCIENCE SEMINAR
  October 6-7
  Pillsbury Auditorium
- FAMILY PRACTICE UPDATE
  October 7-8
  Mall of America Grand Hotel
- ANNUAL ORTHOPAEDIC AND TRAUMA SEMINAR
  October 13-15
  Hennepin County Medical Center
- ECG CONFERENCE
  October 28
  Mall of America Grand Hotel
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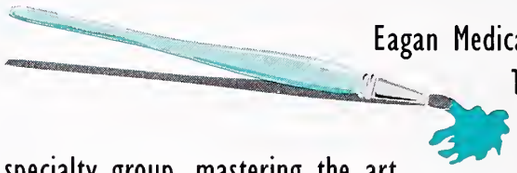

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General Surgeon, Family Practice, Ob/Gyn, Internal Medicine to join progressive 13-physician group practice. Rural college town 30 miles from St. Paul, Minnesota. New clinic and new hospital. Contact: Robert B. Johnson, M.D., River Falls, WI 54022; 715/425-6701. (*5/94-R)

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Family Physicians, P.A., 612/835-3609, or send inquiries to 7801 East Bush Lake Road, Suite 400, Bloomington, MN 55439. (*3/93-R)

Mankato Clinic, Ltd. is seeking additional BC/BE physicians in the following specialties: orthopedics, radiology, invasive cardiology, oncology/hematology, family practice, and general internal medicine. The Mankato Clinic is a 59-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. M. P. Wheeler, President, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (10/93-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

BC/BE Internal Medicine and Ob/Gyn Physician: Excellent opportunity to join a well-established, progressive, 26-physician multispecialty group located in an economically sound community of 22,000 (drawing area of 45,000), 65 miles south of the Twin Cities. Full membership after one year. Competitive salary and fringe benefits package. Contact Craig Oien, M.D., or Terry Tone, Administrator, 134 Southview, Owatonna, MN 55060; 507/451-1120. (9/92-R)

Forest Lake Doctor's Clinic is seeking a BC/BE family physician and ob/gyn to join a growing 12-physician multispecialty practice. Located 25 miles north of Twin Cities in progressive community with excellent schools, outstanding recreational activities. Hospital located across street from clinic. Respond with CV or call Doug Sill, M.D., Harvey Frank, M.D., or Geoff LaGary, Administrator, 121 SE 11th Avenue, Forest Lake, MN 55025; 612/464-7100. (11/92-R)

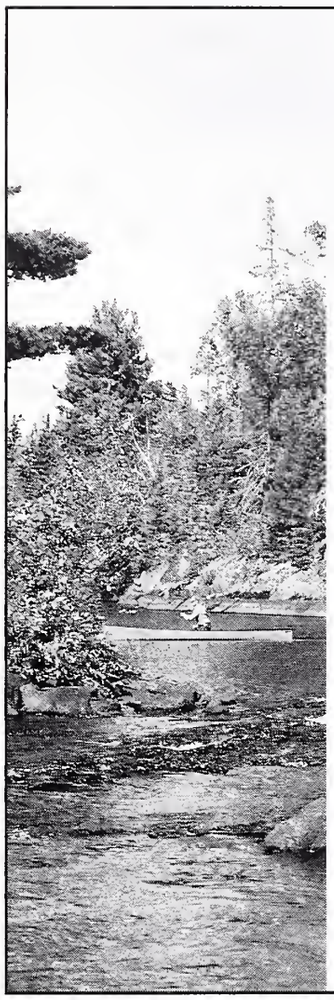
Olmsted Medical Group is seeking BC/BE physicians in the following specialties: emergency medicine and ob/gyn. Great opportunity for well-trained physicians to join a 70-physician multispecialty group in a dynamic, progressive practice. In addition to the main office in Rochester, the group operates eight branch offices in southeastern Minnesota. Excellent salary/benefits package includes malpractice insurance, flexible benefits plan, 401(k) and profit sharing, and relocation assistance. Send CV to Olmsted Medical Group, Attn: Susan Schuett, 210 Ninth Street SE, Rochester, MN 55904. (1/92-R)

Internal Medicine and Dermatology practice opportunities available at the Faribault Clinic. The Faribault Clinic is a multispecialty group practice of 18 physicians. Faribault is located 50 miles south of Minneapolis on I-35. For more information contact Ray W. Wood, M.D., or Ken Smith, Administrator, 924 NE First Street, Faribault, MN 55021; 507/334-3921. (4/94-R)

Stillwater: 20-physician multispecialty group with emphasis on primary care seeking BC/BE family physician. Scenic location with excellent school system, supportive medical community with strong local hospital, competitive salary and benefits. Send CV to Jon Pedersen, St. Croix Valley Clinic, 921 South Greeley, Stillwater, MN 55082; 612/439-2215. (9/93-R)

Family Physician wanted to join six-physician, three-P.A., two-site family practice group in St. Anthony and Shoreview. Obstetrics available. Competitive salary, benefits package, and call schedule. Contact Gerald Pitzl, M.D., Silver Lake Clinic PA, 612/788-9251. (7/91-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)



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Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Edina, Lakeville, Bloomington, and/or at the Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/835-3609, or send inquiries to 7801 East Bush Lake Road, Suite 400, Bloomington, MN 55439. (*3/93-R)

Internal Medicine—Twin Cities/Northwestern Suburbs: Busy, young, four-physician practice. Excellent salary and benefits for the right BC/BE physicians interested in all aspects of internal medicine. Growing hospital and clinic practice expanding to new site. No management duties or buy-in required. Send CV/call Lex Nerenberg, M.D., Bass Lake Physicians, PO Box 29188, Minneapolis, MN 55429; 612/537-6022. (3/93-R)

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- *PEDIATRICS*

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Urgent Care Physicians: Immediate part/full-time positions available at two Convenience Care centers in northwest suburbs of the Twin Cities. Family practice trained providers sought. Excellent opportunity for those physicians seeking freedom from call and hospital responsibilities. Patient base is primarily young adults and children. Attractive hours and compensation. Send inquiries to Robert Kantor, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

Family Physician: Tired of call? Want predictable hours? Full-time physician needed to work three days per week in our ambulatory care centers located in Roseville, Minnetonka, and Eagan. Salary $80,000 minimum and benefits package including malpractice insurance. Also, looking for part-time physicians to cover for Sundays and vacations. Contact Cara Auge or William Wenmark, c/o NOW Care Medical Centers, 13031 Ridgedale Drive, Minneapolis, MN 55305; 612/593-9010. (10/93-R)

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Board Certified/Eligible in Family Practice for a 12 Resident, rurally oriented, Community Hospital based, Family Practice Residency Program. This Mayo Medical Center Affiliated Program will begin July, 1996, in a new Family Practice Center.

Faculty responsibilities include resident education, patient care and administrative duties. Obstetrical experience desirable. Academic appointments available with Mayo Graduate School of Medicine, Department of Family Practice.

Saint Cloud Hospital is a 320 bed, general, acute care institution located on the Mississippi River. Three area colleges and a broad array of cultural, recreational, and retail opportunities make this an ideal community for raising a family, enjoying a "quality life", and practicing medicine. Competitive salary and generous benefits.

Reply: Allan J. Wilke, M.D., Director
St. Cloud Hospital/Mayo
Family Practice Residency
Heartland Building
1520 Whitney Court
St. Cloud, MN 56303

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Student Health Services at Mankato State University seeks a physician to provide outpatient medical care for diverse student population in a comprehensive outpatient center that offers general medical care, laboratory and x-ray services to adolescent and adult students. Health education is a major focus. BC, preferably family practice or internal medicine. Minnesota license eligible. Academic year (nine-month) appointment plus one five-week summer session. No evening or weekend call. Excellent benefits.

Send application letter, CV, and names, addresses, and phone numbers of three references to Donald H. Craig, Ph.D., Director of Counseling and Health Services, PO Box 8400, MSU #21, Mankato, MN 56002; 507/389-6276. MSU, a comprehensive university of 13,000 students located 80 miles south of Minneapolis/St. Paul, is actively seeking faculty and staff that will enrich its cultural, racial, and ethnic communities.

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- ❑ A 380 — physician multispecialty clinic

Contact Patrick Moylan at 612/927-3286
or Fax 612/924/2819
or send CV and letters of inquiry to:

Physician Recruitment
Park Nicollet Medical Center
5000 West 39th Street
Minneapolis, MN 55416

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Internal Medicine—Minneapolis/Northwest Suburbs: Join our eight-physician department as a part of North Clinic's 33-physician multispecialty primary care group practice established over 30 years ago. A physician-owned group with offices in Osseo, Maple Grove, Robbinsdale, and (soon) Plymouth. We admit to North Memorial Medical Center. Contact Tom Harrer, Administrator, North Clinic, 3366 Oakdale Avenue North, Robbinsdale, MN 55422; 612/520-7964. (8/94-R)

Two Family Physicians, BC/BE, to join five-provider medical practice in progressive LeSueur health system (clinic, hospital, and nursing home). New hospital-attached clinic, fall 1995. Picturesque, dynamic community 50 miles south of Minneapolis/St. Paul. Strong industrial base, excellent schools, recreational opportunities, easy access to metro. Competitive salary/benefits. Call 1:6. Contact Jennifer Pfeffer, Administrator, Minnesota Valley Health Center, 621 South Fourth Street, LeSueur, MN 56058; 612/665-3375. *2-9/94

Program Director—Family Practice Midwest: Fifteen residents in this highly acclaimed residency oriented in its teaching to rural medicine. Only program in the state to match all slots. Strong faculty credentials and superb relationship with private attending physicians who participate in the teaching program. Excellent balance of clinical patients with didactic teaching. Full authority and autonomy is vested in the program director to allow effective leadership. Excellent salary and benefits. Contact Wanda Parker, E.G. Todd Physician Search, One Byram Brook Place, Armonk, NY 10504; 800/221-4762. Fax: 914/273-5895. *2-9/94

Medical Director wanted to join Minnesota Mutual, a top-ranked national life insurance and disability income provider. Requirements for this position include board certification (internal medicine/family practice preferred), Minnesota license, and four-plus years of experience preferred. The position allows you to use your medical knowledge to advise the company in mortality and disability analysis, medical claims evaluation, education, and employee health. We offer the opportunity for you to use your expertise in a predictable, yet challenging work environment. Also included is a competitive salary, comprehensive benefits, including health insurance and pension plan, malpractice insurance, payment of continuing education fees, and an opportunity to work part-time clinic hours outside of Minnesota Mutual. Interested candidates are asked to send a résumé or contact Steve Froeschl, Senior Employment Representative, Minnesota Mutual, 400 North Robert Street, St. Paul, MN 55101; 612/228-4982. *1-9/94

Family Practice—North St. Paul, Minnesota: Family practice group of four seeks to fill vacancy. Full range of family practice with ob/pediatrics/geriatrics. Stable community

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Comprehensive Medical Care is a progressive multispecialty clinic located in a rapidly growing Northwestern suburb of Minneapolis. We currently have the following openings:

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Our 23-member department requires an additional BC/BE family practitioner. You will enjoy an average four-day work weekend and on-call duty every 21-23 days.

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The BC/BE Internist we are seeking will join a 3-person department. Interest in both inpatient and outpatient medicine is essential; subspecialty interest is an advantage.

We offer highly competitive salaries with production-based compensation and exceptional benefits that include paid insurance and continuing medical education. Just 20 minutes north of downtown Minneapolis, our location features comfortable suburban living as well as easy access to a wide variety of cultural, educational, and recreational opportunities. To express interest, please send your curriculum vitae to:

John Bordwell, M.D.
Medical Director
COMPREHENSIVE MEDICAL CARE
9055 Springbrook Drive
Coon Rapids, MN 55433
(612) 780-7035

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Gastroenterology	*OB/GYN*
Noninvasive Cardiology	*Urology*

Send your CV to Ken Arndt, St. Francis, Inc., 4541 North Prospect, Suite 400, Peoria, IL 61614; or call 800/438-4592.

clinic since 1946 with excellent growing patient population. Hospital affiliation is St. John's Northeast and HealthEast facilities. Opportunity for one-year salaried position with subsequent buy-in to partnership. Clinic is associated with East Metro Health Organization with multiple insurance contracts. Contact: Marty Dennison, M.D., 2579 East Seventh Avenue, North St. Paul, MN 55109; 612/777-7414. *1-9/94

Minneapolis—BC/BE General Internists needed to join the Department of General Internal Medicine of a 380-physician multispecialty clinic in desirable Twin Cities area. Currently, we have positions available at our Burnsville and Shakopee offices. These are traditional practices with both ambulatory and hospital components. Salary and benefits are highly competitive. For additional information contact Patrick Moylan at 612/927-3286 or send CV and letters of inquiry to Physician Recruitment, Park Nicollet Medical Center, 5000 West 39th Street, Minneapolis, MN 55416; Fax: 612/924-2819 *2-10/94

Wisconsin: 20-physician primary care group is seeking fourth BC/BE internist. Practice the full spectrum of internal medicine. City of 60,000 in west-central Wisconsin, 90 miles from Minneapolis/St. Paul. Competitive salary and excellent fringe package. Contact James Volk, M.D., Medical Director, Group Health Cooperative, PO Box 3217, Eau Claire, WI 54702-3217; 715/836-8552. *3-10/94

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3M Pharmaceuticals, an ethical pharmaceutical company, is seeking a physician board certified in internal medicine or international equivalent, for the position of Assistant Director, Clinical Research. Candidates should have good interpersonal and communication skills. Clinical experience (5 year minimum) and a strong medical background are required. Additional training in asthma or pulmonary disease, required. As an equal opportunity employer, 3M offers an attractive benefits package as well as opportunity for professional development.

Interested, qualified candidates should contact:

Edward H. Erickson, Ph.D.
Director, Research and Development

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Building 270-3A-01, 3M Center
St. Paul, MN 55144-1000
612/733-3945

3M

Family Practice Physician needed to join established group of five FPs and one pediatrician in northwestern Wisconsin community of 8,000 with service area of 40,000—located on the doorstep of Wisconsin's fabulous lake country. Practice medicine in a small, family-oriented community within two hours of Minneapolis/St. Paul. Competitive salary and excellent fringe benefits. Send CV to James Volk, M.D., Medical Director, PO Box 3217, Eau Claire, WI 54702-3217; 715/836-8552. *3-10/94

Wisconsin—Family Practitioner Needed by progressive and growing group practice in west-central Wisconsin city of 60,000. Ninety miles from Minneapolis/St. Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high-quality care in a good recreational area. Send CV to James A. Volk, M.D., Medical Director, PO Box 3217, Eau Claire, WI 54702-3217; 715/836-8552. *3-10/94

Wisconsin—Third BC/BE Obstetrician/Gynecologist needed to join stable, progressive, primary-care-based HMO/group practice in university town of 60,000 near Minneapolis/St. Paul. Excellent quality of life and outstanding recreational area. Competitive salary and fringe benefits. Contact: Medical Director, Group Health Cooperative, PO Box 3217, Eau Claire, WI 54702-3217; 715/836-8552. *3-10/94

Physician—Family Medicine: The East Metro Community Health Network is seeking a BC/BE family medicine physician with an interest in community-based health care to provide primary health care services for clients of member clinics and health departments. The ideal candidate will have an interest in working with low-income/minority community populations. Must be licensed to practice in Minnesota. Attractive hours, salary, benefits. No call. Full- and part-time positions available. Interested applicants send CVs to: East Metro Community Health Network, 50 West Kellogg Boulevard, Suite 930, St. Paul, MN 55102; 612/266-2515. Equal Opportunity Employer. *2-10/94

Occupational Medicine Specialist, BC/BE, FT, to join established group of eight physicians providing care for diverse employer-client base in St. Paul and Eagan, Minnesota. Excellent communication skills, strong commitment to patient care with MRO and IME experience. Competitive earnings and benefits. Contact: Debbie Modder, HealthSpan, 2810 57th Avenue North, Minneapolis, MN 55430; 800/248-4921 or 612/574-8803. *3-11/94

Urgent Care, Pediatrics, and Family Physicians needed by 27-physician multispecialty group in St. Cloud, Minnesota. Provide an excellent call schedule, flexibility in your scheduling for time off, and a very comprehensive benefits and salary program. If interested in joining a growing and young group of physicians in central Minnesota, please send your CV and/or call Daryl G. Mathews, Administrator, St. Cloud Medical Group, 1301 West Saint Germain, St. Cloud, MN 56301; or call collect, 612/251-8181. *4-11/94

Family Practice, BC/BE, to join progressive 25-physician multispecialty group practice. Rural setting with metropolitan practice style, 25 miles from Minneapolis. Group has excellent reputation and large geographical referral area. Recently expanded facility is adjacent to newly remodeled 110-bed hospital. Comprehensive benefits package with excellent remuneration. Interested physicians should contact Joseph E. Van Kirk, M.D., or Scott D. Ellingson, M.D., Lakeview Clinic, Ltd., 424 State Highway 5 West, Waconia, MN 55387; 612/442-4461. AA/EOE. *3-11/94

Explore the Possibilities! We are currently seeking primary care physicians specializing in family medicine, pediatrics, occupational medicine, internal medicine, and ob/gyn for a variety of group practices throughout the Midwest and New York State. Surgical and subspecialty physicians are also needed for a variety of locations. We represent practices in all types of settings in communities of every size. New opportunities become available every month. Whether a practice change is imminent or just a future consideration, we have the information you need. Call 800/243-4353 or write to Strelcheck & Associates, Inc., 10624 North Port Washington Road, Mequon, WI 53092. *3-11/94

Internal Medicine: BC/BE internist for 84-physician multispecialty group on the scenic bluffs overlooking the Mississippi River where Iowa, Illinois, and Wisconsin meet. Excellent call schedule in this 17-member department of physician-owned clinic with its own HMO. Professional administration enables physicians to concentrate on the practice of medicine. Outstanding lifestyle, excellent income guarantee, complete benefits and ownership eligibility. Call or send CV to Denis Albright, Medical Associates Clinic, 1000 Langworthy, Dubuque, IA 52001; 800/648-6868. 3-11/94

Family Practice—Wabasha, Minnesota: Well established group of five family practitioners is recruiting two additional FPs. A Mayo Regional Practice. Physicians are all Mayo employees. Busy practice at three sites with the full range of services, including ob and ER. Competitive financial package. Comfortable small community located on the shores of the Mississippi River and within commuting distance to Rochester and LaCrosse. Site of the popular movie "Grumpy Old Men." Excellent lifestyle. Fabulous recreational opportunities available. Good schools. Low crime area. Contact Christopher Kashnig, PO Box 1100, Oshkosh, WI 54902; Call 414/236-2430; Fax: 414/236-1312. *4-12/94

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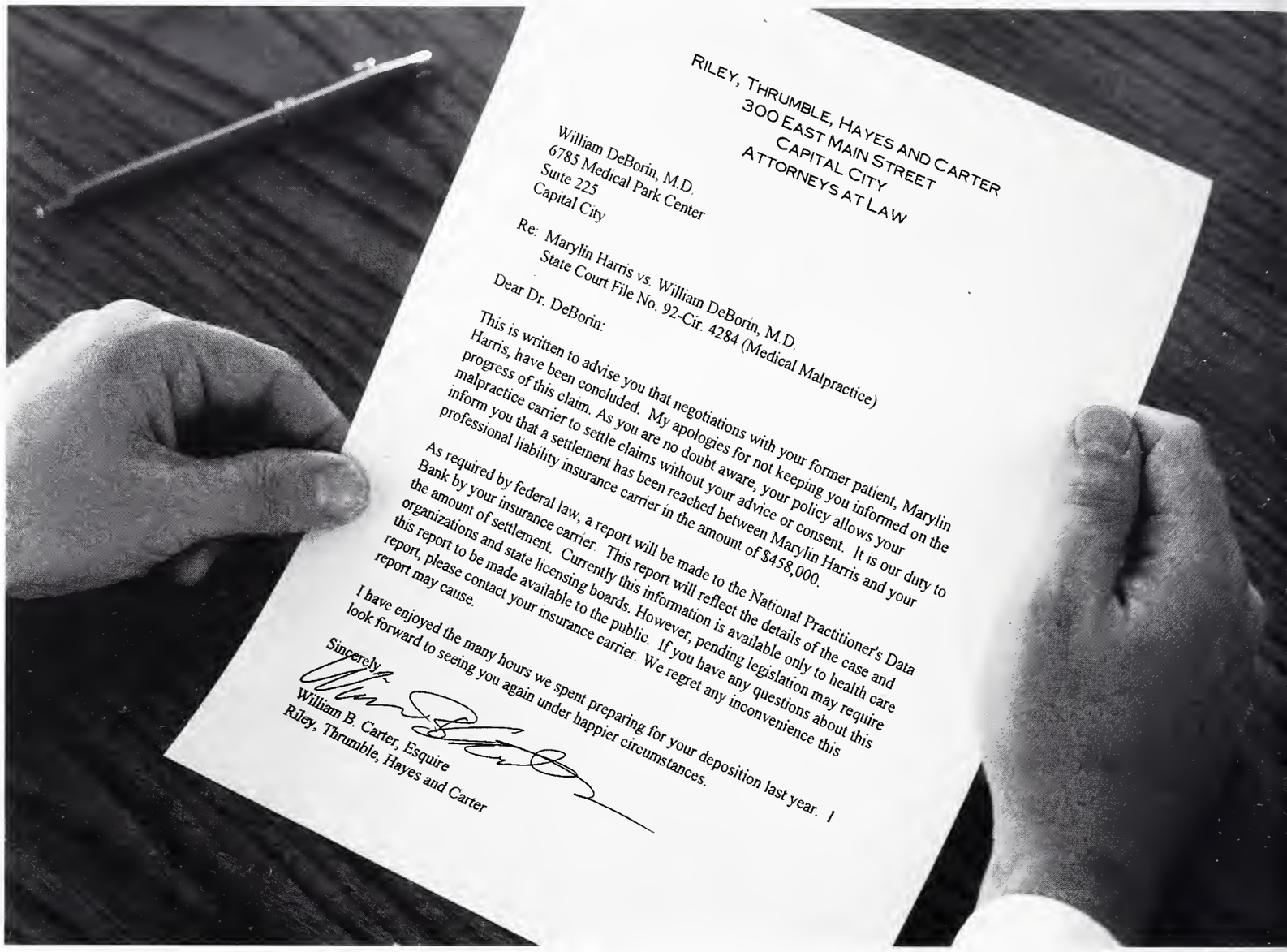

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Pervasive Violence Calls for Introspection, Intervention

Charles R. Meyer, M.D.

"In this age of the rule of brute force, it is almost impossible for anyone to believe that anyone else could possibly reject the law of the final supremacy of brute force."
–Mahatma Gandhi

The August headlines keep coming back to me—the gruesome story of two St. Paul police officers shot in the line of duty, the city's first police shooting in 24 years. Although residents of violence-hardened cities like New York and Chicago may scoff at the Twin Cities' "problem," the message from statistics is clear: Minnesota is no haven from the ballooning violence of our society. Indeed, the numbers are overwhelming enough to induce bilateral actionoplegia, a paralysis of constructive response bred of helplessness. But Minnesota is not so afflicted. This *Minnesota Medicine* tells stories of people who daily "reject the law of the final supremacy of brute force."

Our Face to Face profile spotlights the two winners of the MMA's "Stop the Violence" award, Stuart Hanson, M.D., and Susan Hadley, M.P.H., and tells the story of their anti-violence work through organized medicine's quest for a violence-free society and WomanKind's help for battered women. This month's Public Health Series documents the tight knot between chemical abuse and family violence and provides concrete suggestions for physicians dealing with these problems. Our cover story on the Duluth Domestic Abuse Intervention Project depicts the development of a program that unites the entire community to stop abuse. The feature on child abuse comprehensively covers the history, signs, symptoms, and treatment of child abuse and neglect.

"Domestic violence is not just a social evil; it is a medical problem."

These articles suggest several generalizations: 1) Domestic violence pervades society. It crosses social, economic, and racial boundaries. 2) Individuals can have an impact on this widespread problem. Stu Hanson, Susan Hadley, and Ellen Pence of the Duluth project are proof of that. 3) Domestic violence is not just a social evil; it is a medical problem with symptoms, complications, treatments, and huge societal costs. 4) Help is available for the injured, the injurers, and the health professionals who diagnose domestic violence.

But behind these articles is a haunting thought that we are only applying Band-Aids while the underlying disease marches on, unchecked. The illness is not out stalking the streets or running in the sewers, but is lying within ourselves. Secretary of Health and Human Services Donna Shalala wrote in the Winter 1993 *Health Affairs*:

"Here are some questions to ask ourselves: What is my own attitude toward the use of violence to settle disputes? Is it ever justified? Do I keep a loaded gun in the house? If so, why? How do I react when I approach a group of urban youth on the street? Do I enjoy watching gratuitous violence on television and in movies, and do I allow the proliferation of violence in the entertainment media to have any influence on my behavior?"

To truly change society, we must engage in a little introspection about how we act, what we teach our children, and what actions we condone in others and in our media. Do we, as Mark Twain suggested, "when angry, count four; when very angry, swear," or do we strike out physically? If we learn violent ways to resolve conflicts, almost as consistently as brown eyes, we will pass it on to our descendants.

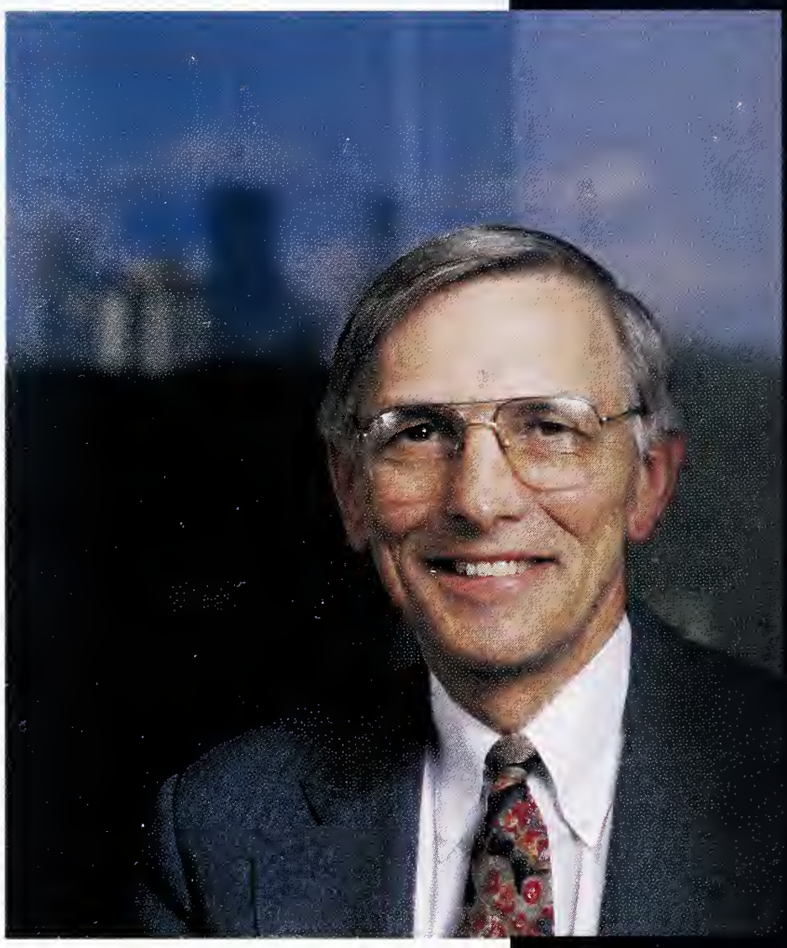
Changing ourselves and society is a tall order. The forces of violence are clearly imposing. But I am reminded of an expression from the '60s: "raising consciousness." I'm not sure I truly understood this phrase during that era, but now I realize that it means changing what is acknowledged to be acceptable in society. It means driving drunk is no longer a joke. It means slurs against "other groups" are unacceptable. Our consciousness of violence in our lives is being raised, but we have miles to go.

I return to Mahatma Gandhi: "Do not resort to violence even if it seems at first to promise success; it can only contradict your purpose. Use the means of love and respect even if the result seems far off or uncertain. Violence can never bring an end to violence; all it can do is provoke more violence." By causing people to look inward, Gandhi freed his nation. By examining our actions and our values, we can move closer to Dr. Hanson's violence-free society. MM

On the Front Lines

By Margaret Rog

A. Stuart Hanson, M.D.



Like most people, A. Stuart Hanson, M.D., has a dream for the world his grandchildren will grow up in. The future he imagines looks something like this:

It's a place where everyone has the skills to interrelate, both at work and at home, in a non-abusive way. Everyone has the skills to resolve conflict without using force. No one has to worry about being on the streets at night. No one has to worry about getting beaten up—physically or emotionally—at work.

Hanson, 57, doesn't have any grandchildren yet. His son is a physician in Minneapolis and his daughter is finishing her Ph.D. at the University of Pennsylvania. But 16 years from now, in the year 2010, little lap-warmers there may be. That's the year Hanson hopes—make that expects—our society will be violence-free.

Hanson has reason to be optimistic. He's at the leading edge of domestic abuse and violence prevention, working with physicians and others to promote awareness of abuse within the medical community. It's for this reason Hanson received the Minnesota Medical Association's first annual Stop the Violence Award. In 1988, when few in the health care field considered violence and abuse a problem within their own ranks, Hanson, then a Hennepin County Medical Society board member, directed the HCMS to spend time and resources studying the problem. The result, by 1991, was a series of projects designed to identify and address workplace abuse, such as harassment and intimidation at area hospitals and clinics, including North Memorial, Park Nicollet, the University of Minnesota, Fairview Riverside, Fairview Southdale, and Methodist.

Hanson gained a larger audience for his anti-violence message when he became MMA president in 1992 and made domestic abuse and violence prevention the theme of his presidency. On Hanson's watch, the MMA successfully carried out a media campaign that reached more than 1 million Minnesotans with the message that violence, both at home and at work, must be stopped. Hanson and the MMA also developed a resource list for victims and physicians designed to encourage referrals. The list, as well as written guidelines to help physicians diagnose abuse, was distributed to every clinic and hospital in Minnesota in 1993 (the resource guide appears on pages 29 and 30).

Still, Hanson insists he's a catalyst, not a leader, in promoting domestic abuse and violence prevention. "I've raised the issue, but really, others have taken [it] on, carried it forth,

"If we don't believe it's possible to end violence, it won't be."

–Stuart Hanson, M.D.

Dr. A. Stuart Hanson and Susan Hadley, winners of the MMA's first annual Stop the Violence Award, marshal health care forces to halt domestic violence.

done a lot of the work," he says. Hanson credits fellow award-winner Susan Hadley, as well as many others, with blazing the trail and doing important hands-on work with victims and physicians.

"Getting our own house in order" is Hanson's mantra whenever he talks about violence and abuse prevention. "Rather than pointing to somebody else to change their behavior," he says, "we [need to] look at our own environment in health care and ask, what can we do to improve the environment we work in? How can we take what we learn at work into our homes and make our homes abuse-free?

"I have this idea that if we get our own house in order, as a health care system," he explains, "we'll have come a long way toward saying, 'Here's how you do it. Here's how we can create abuse-free environments for city workers, corporate workers, how we can teach people to be better parents.' "

Hanson doesn't ignore the problem of abuse and violence outside the medical community, or the importance of physician intervention when domestic violence is suspected in a patient's life. He emphasizes cleaning up the medical community's own act because problems there have historically been underemphasized. "In order to help others, we need to help ourselves first," he says.

The Park Nicollet Medical Foundation president and pulmonary medicine specialist has four primary areas of professional interest: health system reform, fitness and nutrition, violence and abuse prevention, and tobacco-use prevention. As president-elect of the Minnesota Smoke-Free 2000 Coalition, Hanson credits grassroots awareness projects similar to the MMA's Stop the Violence Campaign for radically changed social attitudes about smoking. He easily draws comparisons between preventing tobacco use and domestic abuse.

"If we can change people's attitudes about clean air, and get them to value clean air, can we also get them to change their attitudes about the use of violence and abuse as a means of controlling another person?" Hanson asks. "Can we get people to value nonviolence enough to eliminate [violence] from their own lives?"

Hanson thinks so. "If we're going to live together, we have to," he insists. "If we don't believe it's possible, it won't be." MM

Susan Hadley, M.P.H.

Susan Hadley, M.P.H., used to be angry. Years ago, as a graduate student and mother of two young children, Hadley regularly attended meetings of the National Organization for Women. "I would come out of those meetings thinking, 'this world is not right,' " she recalls.

Meanwhile, Hadley was also volunteering on a crisis line for battered women. Listening to the women's stories helped crystallize Hadley's ideas about injustice in the culture and inequality in personal relationships. Through her own research, she discovered that the health care system was not responding appropriately to the needs of battered women.

Hadley, founder of the nonprofit WomanKind, couldn't keep her anger bottled up. "I needed to focus that anger, plus I wanted to do something to make this world a better place," she says. "That's how WomanKind came about. That's where the anger went."

A decade later, WomanKind, a support system for battered women, has four full-time staff members, more than 100 volunteers, and a $200,000 annual budget. The program has served more than 7,000 women since its inception in 1986.

Hadley's program has two primary purposes: to provide advocacy services, crisis intervention, and ongoing assistance to battered women; and to educate hospital staff, physicians, and community health professionals so they can identify and treat battered women.

It's a two-pronged approach that Hadley believes is crucial to WomanKind's success. "I think, ethically, if you're going to provide the education [to physicians], you'd better have an in-house service available for [women who are referred by physicians]," she says. "You can't do one effectively without the other."

WomanKind has won national acclaim for its successful integration into the health care system. The program has been profiled in the *Journal of the American Medical Association* and the *Journal of Emergency Nursing*, among other publications. Recently, the Centers for Disease Control and Prevention selected WomanKind as a model program to be evaluated for possible replication in hospitals around the nation. Hadley, herself, was recognized September 29 when she received the Minne-

sota Medical Association's first annual Stop the Violence Award for her work in preventing domestic violence and abuse in Minnesota.

In 1992, Hadley sold WomanKind to the Fairview Health System and the program was given departmental status within Fairview. This has given the program greater recognition and support, says Hadley, who stayed on as executive director. "I know that if I'm sitting there in a meeting [representing a department], domestic abuse is being recognized as a major public health issue."

Hadley's program hasn't always enjoyed the level of support that it does today. Back in 1985, when domestic abuse was not yet a popular issue, she proposed the idea of a program to help victims of abuse to administrators at Fairview Southdale Hospital. Her plan wasn't immediately embraced. "There was a certain reluctance to deal with the issue, to acknowledge the problem of domestic abuse," she recalls. Still, Hadley was offered an office and other in-kind support, and six months later started providing services to battered women.

As WomanKind's client base has grown, so has support for the program. WomanKind now enjoys financial support from the Fairview Hospitals Auxiliary, the Fairview Foundation, and Fairview Health System. And recruiting volunteers has never been easier. "I go to WomanKind volunteer trainings, and I say, 'You can't know what this means to me to see a whole room of you who want to do this work,' " Hadley says.

But the real rewards for Hadley are the success stories: women who "get in touch with their inner strength" and work to resolve an abusive relationship. Hadley fondly tells the story of "Liz," one of WomanKind's first clients, whose husband's abuse landed her in intensive care. With Hadley's help, Liz separated from her husband, both sought counseling, and, after much hard work by both Liz and her husband, the couple later reconciled. Recently, Liz appeared on a "Today" show segment featuring WomanKind as an innovative solution for reaching victims of abuse through the health system. "When Liz arrived for the taping of the show carrying a newborn, we all started crying," Hadley recalls.

Hadley now spends her time managing the WomanKind program, teaching health professionals, consulting, writing, and helping others set up similar programs in hospitals around the nation. Recently, Hadley worked with a team of physicians to write the American Medical Association's "Diagnostic and Treatment Guidelines on Domestic Abuse." But integrating WomanKind into Fairview's health care structure is itself a full-time job, she says. "It's constant, nonstop, unrelenting education and marketing. I could do it all day every day and never be finished." MM

Margaret Rog is a free-lance writer based in St. Louis Park, Minnesota.

"I wanted to do something to make this world a better place."

–Susan Hadley

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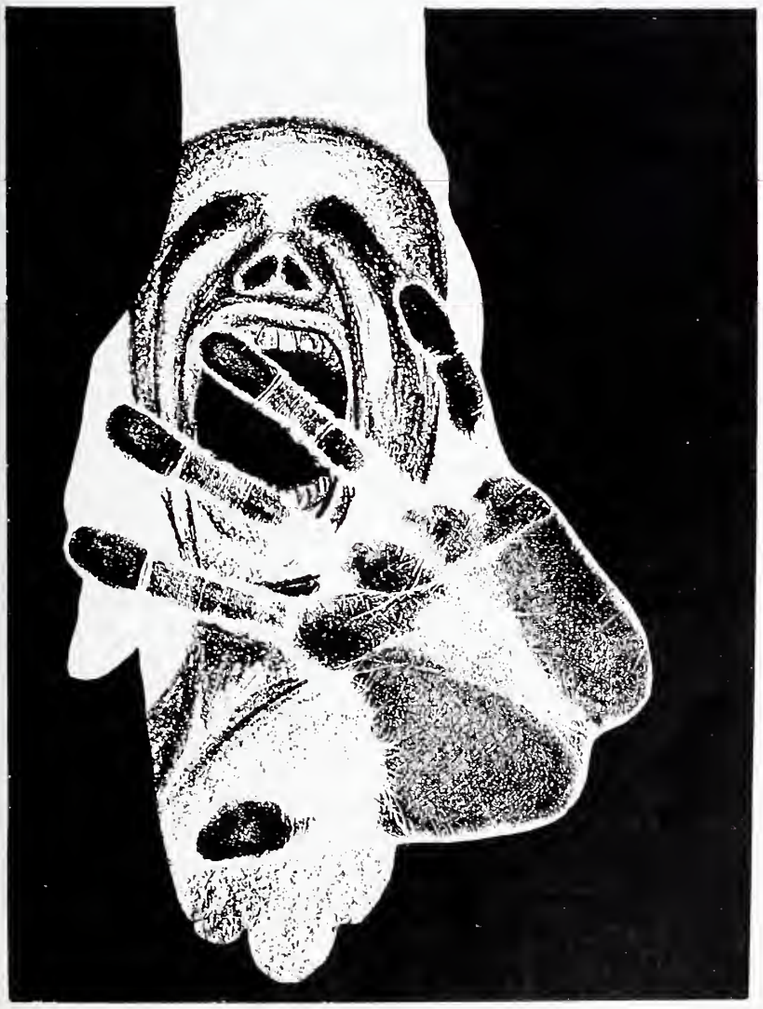

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Duluth Takes on *Domestic Violence*

The Duluth Domestic Abuse Intervention Project's response to abuse is swift and sure and its message clear: the community won't tolerate domestic violence.

By Miriam K. Feldman

It's a typical day at the Duluth Domestic Abuse Intervention Project, and the staff has some 50 calls to return. There's one from the city's legal aid office and another from a local judge—calls the staff will return first, since they are likely to deal with the business at hand, which is a coordinated community response to domestic assault.

Staff member Ellen Pence will be returning a call from a police sergeant in Montgomery, Alabama, and another from a women's shelter in Urbana, Illinois. There are messages from the Institute for Law and Justice in Virginia, and the State Coalition for Battered Women in Nevada. There's an inquiry from Albuquerque, New Mexico, on how to get probation officers to do pre-sentence investigations, and the Los Angeles city attorney's office has a question, not about the O.J. Simpson case, but if they were to ask, Pence has thoughts on that subject, too. All these calls attest to the Duluth project's renown.

Duluth, a Great Lakes city known for its harsh winters, has in recent years been acclaimed as the place that creatively and successfully took on domestic violence. Communities in all 50 states and some half dozen countries have studied what has come to be known as the "Duluth model," an innovative approach to dealing with domestic assault. The model has been cited in textbooks and featured in everything from the *Journal of the American Medical Association* and *Woman's Day*, to *The New York Times Magazine*.

Long before the O.J. Simpson case catapulted the issue to the front pages, the Domestic Abuse Intervention Project (DAIP) had been chipping away at domestic violence, which touches more than one-fourth of all American families and is responsible for more than a third of all female murders. And long after the fickle public turns its attention elsewhere, the DAIP will be there, "the constant, heckling monitor," as *The New York Times* has called it, reminding the community that in Duluth, it is not OK to beat a woman. (Although men are also victims of domestic abuse, the statistics are overwhelmingly one-sided. Family violence is the single largest cause of injury to women in the United States, more common than automobile accidents, muggings, and rapes combined. It accounts for 35 percent of women's visits to hospital emergency rooms.)

The Duluth model "has been proven to be one of the few things that work, to hold batterers accountable and make the criminal justice system do what it's supposed to do, which is protect victims from repeated assaults," says Julie Tilley, communications coordinator for the Minnesota Coalition for Battered Women.

Since 1981, the DAIP has been monitoring every local agency that deals with domestic abuse, from police and prosecutors, to probation officers and judges. Over the years, the project has grown to include a program for men who batter; women's support groups; parent groups; a supervised center that is supposed to be a neutral, safe place for the exchange or visitation of children; and training programs for communities here and abroad.

In recognition of the group's efforts, the Minnesota Medical Association presented its first annual Stop the Violence Award to the DAIP September 29 at the MMA's Annual Meeting in St. Cloud. (As part of the MMA's ongoing Stop the Violence Campaign, it also awarded a physician and a nonphysician for their efforts to end domestic violence—see page 6.)

"The Duluth Domestic Abuse Intervention Project is truly a nationally and internationally recognized intervention project," says Mark Vukelich, MMA director of communications. "Long before domestic violence and abuse became a major media event, they were out there doing this."

The MMA award wasn't DAIP's first. In 1988, it received the Innovations in State and Local Government Award from Harvard University's School of Government and the Ford Foundation. In 1983, the Minnesota Corrections Association honored the DAIP with its President's Award.

By all accounts, much of the DAIP's success goes to Ellen Pence, 46, a project founder, known for her ability to make things happen. Eli Radulovich, a retired police inspector who was involved with the project from the start, attributes much of the program's success to Pence's steady manner. "No matter how the people approached her, she never reacted. She's so very cool. I think that helped," Radulovich says.

The DAIP avoids showdowns, Pence explains. "We don't try to publicly get into confrontations with people in the system, because in the long run we want to have a working relationship." In the same breath, however, she grants that the DAIP is the "squeaky wheel," making enough noise to ensure that domestic cases don't take a back seat to anything. "In domestic violence cases," she says, "you have to have someone who's always out there, pushing it as a priority item."

Even a city the size of Duluth has several hundred

people—police, judges, bailiffs, sheriffs, physicians, therapists, probation officers—individually intervening in domestic abuse cases. The Duluth model stipulates that every one of them will follow an agreed upon set of community practices and protocols. "We try to think of it as an orchestra, and everyone has sheet music," explains Pence. The protocols assure that when the horns have to play, they don't come in at the wrong time.

This coordinated community response works. It isn't a cure for domestic violence, but it is a swift and sure response that sends the message that the community will not tolerate domestic abuse. In Duluth, batterers are held accountable for their behavior, and victims feel that the system looks out for them. Prior to 1981, victim advocates couldn't tell victims how a case would be handled. "I always had to say, 'I don't know what they'll do,' " says Pence. "Now I can explain how the process works. We know that if someone calls 911 to report abuse, a squad car will go to the scene. If there is injury and evidence of assault, there will be an arrest. If the [abuser] is court ordered to a rehabilitation group and he doesn't go, a warrant will be issued for his arrest."

Arrest and prosecution rates alone, however, aren't a measure of success. "How many convictions you make doesn't tell if [the project] is working," Pence says. "We evaluate and judge our project from the standpoint of the women who turn to the system. Is their position enhanced or diminished by the system?"

By that measure, the DAIP has been a triumph. In two-year follow-up interviews, 81 percent of the women who went through the system say they are living in a violence-free situation; 78 percent say the system was helpful or very helpful to them; and 71 percent say the police were very helpful. Pence sums these figures up in one word: rare.

In many communities, victims are left to feel that somehow they are to blame for the abuse. They perceive the system's response to be cavalier—even punitive. The DAIP works hard to root out this response. "If you don't give any air, water, or light to a plant, it dies," Pence says. "We're trying to not give air, water, or light to victim-blaming."

The DAIP was conceived carefully and deliberately by Pence and others from around Minnesota in the battered women's movement, who set out in 1980 to design "a perfect community response" to the problem of domestic violence. Pence, who is not a victim of abuse, had been drawn into the movement as a volunteer after her aunt was killed in a domestic dispute. By 1977, Pence was working full time with the Department of Corrections in St. Paul as Minnesota's first director of battered women's programs, overseeing the funding of all the newly emerging women's shelters in the state. Within three years, she realized that this wasn't enough. True, women were finding shelter from the violence in their lives, but men were continuing to batter with impunity. Nothing much had changed.

So Pence and a few other women, primarily victim advocates from battered women shelters, looked around the country for model programs. They found a good prosecution program in San Francisco and a successful jail visitation program in Florida. They put the best of everything into one package and shopped for a community willing to try something new. Their search ended in Duluth, where the police chief was willing to take a risk, and judges were willing to listen.

Pence moved to Duluth to set up the program with Shirley Oberg, a founder of the Duluth shelter. "Shirley had links in the system and was able to find allies to take on the issue—police inspector Eli Radulovich, probation officer David Nyquist, local counseling agencies, and, later, prosecution officer Mary Asmus," Pence says.

Stop the Violence

The Minnesota Medical Association's "Stop the Violence" Campaign combats domestic violence through a number of programs. The goal: educate physicians and the public that physicians have a unique role to play in patient intervention. The association's latest efforts include a physician resource guide that explains how physicians can intervene and lists referral numbers (see pages 29 and 30); a November 4 seminar co-sponsored by the MMA and the Hennepin and Ramsey county medical societies called "Beyond Broken Bones and Black Eyes: Can You Identify Abuse? How Will You Respond?"; and a button physicians can wear that reads, "It's OK to talk to me about family violence and abuse."

In recognition of its efforts to stop the violence, the MMA has won three awards this past year: Gov. Arne Carlson's Violence Free Minnesota Award, the Minnesota Society of Association Executives' Excellence in Communication Award, and the American Society of Association Executives' Summit Award—the highest level of recognition in the organization's Advance America Awards program. The MMA and seven other associations were chosen from 240 entries to receive the Summit Award for activities that significantly benefit

With hard work, some good luck, and a few good people in the right places, it all came together.

Radulovich was one of the people who made it happen, although he insists that he was merely doing what he believed in. What he did was make sure that his officers adhered to the new mandatory arrest policy.

"I was completely in favor of mandatory arrest," says Radulovich, who won an award in 1985 for his work in domestic abuse from the International Association of Chiefs of Police and *Parade Magazine*. Not everyone embraced the new policy, however. "It was hard for people to accept change overnight," he recalls.

Before 1981, police had no authority to make an arrest in domestic assault cases unless the crime was committed in their presence. "I used to see some pretty good beatings, some broken jaws," Radulovich recalls. "At that time, all we did was mediate, quiet people down, and leave. We did not have the authority, under the law, to make an arrest." An arrest could be made if a victim brought charges, but given the psychological power that batterers hold over their victims, that rarely happened.

A lot of officers didn't believe in the policy. It hadn't been part of their training, and, perhaps more importantly, it hadn't been part of their upbringing. "They might have been brought up in a home where the man was lord," Radulovich explains. Some felt that any dispute between a husband and wife should be settled in private.

Mandatory arrest is just the beginning of a process that holds batterers accountable for their behavior. All down the line, everyone in Duluth has a part to play. The jail must hold the batterer until he is brought to court in the morning. And the court has to assess any danger to the victim, as well as notify the shelter before his release. Prosecutors agree to seek convictions and to proceed regardless of victim cooperation. Plea agreements are discouraged, and elevated charges for second offenses are expected. Probation officers are supposed to follow up on their cases and obtain input from counseling programs and victims. Judges are expected to follow sentencing guidelines.

"You don't want a judge to give a

society and make America a better place to live. Former host of CBS' "Sunday Morning," Charles Kuralt, presented the award to MMA Director of Communications Mark Vukelich at a ceremony in San Francisco August 30.

As part of its Stop the Violence Campaign, the MMA started an annual awards program this year to recognize a physician, a nonphysician, and a group from Minnesota for their efforts to end violence. At this year's MMA Annual Meeting in St. Cloud September 29, the MMA awarded the Duluth Domestic Abuse Intervention Project, Dr. A. Stuart Hanson (see page 6), and Susan Hadley (see page 7).

The MMA's Stop the Violence Campaign has also included:

- public service announcements on radio stations throughout the state featuring Christian Laettner of the Minnesota Timberwolves;
- 40 billboards throughout the Twin Cities and greater Minnesota that read: "Doctors Can't Cure Family Violence. But They Can Help!"
- a resolution to the Minnesota Medical Association calling on the MMA to adopt a policy opposing the denial of insurance claims to victims of domestic violence and abuse. The resolution also calls on the MMA to seek legislation that would prohibit insurance discrimination and to forward a similar resolution to the AMA House of Delegates. (As *Minnesota Medicine* went to press, this resolution was being discussed at the MMA Annual Meeting, September 28-30.)
- a resolution to the AMA asking the organization to use all its energy and dollars to achieve a violence-free society by the year 2010;
- a "Hands Are Not for Hitting" campaign aimed at children, which has since become a national campaign. The MMA, together with the Minnesota Coalition for Battered Women, designed and printed a poster and brochure for use in physician offices, clinics, and hospitals to encourage victims to seek help; and
- a workshop for judges and community leaders from the 10 judicial districts, organized with WomanKind of the Fairview Health System.

For more information about the November 4 seminar, or for copies of Stop the Violence materials, contact Mark Vukelich at the MMA, 612/378-1875.

lecture to a guy who's beaten up his wife. You want a sanction," Pence explains. What's more, she says, you want a harsher sanction each time he's brought before the court. "We're mixing rehabilitation and sanction, with each repeat assault resulting in harsher sentencing."

Such a carefully orchestrated response to domestic violence depends upon everyone sticking to the rules, a point underscored by Pence at a recent three-day seminar for professionals who work with men who batter. Pence illustrated her point by describing a case the DAIP had handled involving a man who had beaten his wife and was ordered by the court to attend one of the project's counseling groups. During the 16th week of a 24-week program, he told the group therapist that he had recently lost control and pushed his wife.

"What should the therapist do?" Pence asked the group, as she presented a menu of options, which included reporting the man to his probation officer and recommending either a jail sentence or leniency. Other possibilities included not reporting the offense; asking the victim what to do; recommending couples therapy; or suggesting group therapy for the victim.

Seminar participants, who had gathered from all over the country to study the "Duluth model," were willing to give the guy another chance. As one woman explained: "We're trying to strike a balance of seeing justice and not stopping the progress he's making [in group counseling], however slow it might be." Her solution was to ask the victim what to do and suggest that she join a counseling group for women.

Wait a minute, said Pence. "Don't forget, he's beaten her up 40 times over 12 years and this is the first time he's been arrested and brought to court." A basic rule of the Duluth model, Pence told the group, is that every new offense has a new consequence. In this case, the man spent a weekend in jail.

The point of the exercise was to demonstrate why adhering to policies is better than allowing individuals to make decisions. In Duluth, the policy states that therapists must report incidents to probation officers. The decision is out of their hands.

Another story Pence tells further explains the importance of following protocols. One of the first persons to be arrested under the DAIP's protocols was a 19-year-old woman who looked 12, had a two-month old baby, and was in jail for assaulting her husband.

Following the rules she had helped create, Pence visited the young woman in jail. The woman talked to Pence about her anger with her husband, who hadn't spoken to her since her refusal to have an abortion. In frustration, the woman had poured ketchup on her head at dinner, hoping to get him to talk. He called her "a stupid bitch," at which point she nicked him in the ear with a butter knife. The police, adhering to the new mandatory arrest policy, took her to jail.

After the young woman had finished telling her story, the jail matron turned to Pence and said, "See how stupid your policy is?" Pence, already aware of police resistance to the new policy, agreed and took the woman home.

When they arrived, another DAIP member was there, visiting the victim—again according to the rules. By this time, Pence was willing to believe that the new policy was too rigid; she had doubts that the man in this case truly was the victim.

But when she saw the man, she realized the true importance of the policy. He had been cut from the top of his head down to his chin. "Everything the woman told me was a lie," Pence says.

"I was the first person to break a policy. Policy was, hold them until you've got a full picture of how safe the victim is. That's why we wanted [individuals] to lose discretion. Because they're all like me. They don't really have a full picture," says Pence, who estimates that perhaps as many as 90 percent of the cases would get screened out of the system if individuals handling these cases relied on their limited knowledge of the facts and their own judgment. Under the DAIP, everyone knows the score. "We agree by coming together that we can count on each other using policy and protocol."

The DAIP currently is working with 350 men, an equal number of women, and many children. To date, 3,500 men—one of every 19 in Duluth—have been ordered by the court to attend the DAIP program for batterers. Even so, the fight against domestic violence is an uphill battle. True, the intervention project is regarded a success, but it hasn't done much to curb the violence. In 1992, Pence told *The New York Times*, "We have no evidence to show that it has had any general deterrent effect. The individual guy you catch may do it less. But in Duluth, men don't say, 'Gee, I shouldn't beat her up because I'll get arrested.'"

The aggression won't stop, Pence says, until the message goes out that it's unacceptable. That message needs to come from churches, schools, the media, and other institutions that shape the way people think, she says, and it needs to be heard by a community much larger than Duluth. MM

Miriam Feldman is a Minneapolis free-lance writer and a frequent contributor to Minnesota Medicine.

This drawing was done by a 5-year-old girl who was physically and emotionally abused by her mother and sexually abused by an uncle.

Child ABuse

As any parent, teacher, or physician will attest, America is fast becoming a dangerous place for kids. Unfortunately, for many children, home is no haven. Nationwide in 1992, an estimated 1,261 child abuse- and neglect-related fatalities were reported to child protection agencies. In more than half of child maltreatment cases, parents or caretakers are the perpetrators. Child abuse is a pervasive societal problem that demands an equally pervasive community response that puts physicians on the first line of defense.

Larry W. Mens

There was an old woman who lived in a shoe; She had so many children she didn't know what to do; She gave them some broth without any bread; She whipped them all soundly and put them to bed.

Nursery rhyme, 1797

History of Child Maltreatment

Aristotle once wrote, "The justice of a master or a father is a different thing from that of a citizen, for a son or a slave is property, and there can be no injustice to one's own property." Sexual initiation of students by Greek philosophers was considered the norm.

Lloyd de Mause, in "The History of Childhood," notes that not until 374 A.D. did the Roman Empire pass a law declaring the killing of an infant murder. Even with such laws, however, killing illegitimate offspring continued into the Middle Ages. In fact, de Mause writes that "the history of childhood is a nightmare from which we have only recently begun to awaken."[1]

During the fourth to 13th centuries, children were generally left with a wetnurse from the time of birth until weaning, sometimes up to five years. Children were sold by their parents into slavery or used as political hostages or as security for debts. Many were apprenticed by age 7 to learn a trade.

Between the 14th and 17th centuries, swaddling, head binding, tying children to

General Indicators of Child Abuse and Neglect

The Child

- shows sudden changes in behavior or performance;
- has not received help for physical or medical problems brought to the parents' attention;
- has learning problems that cannot be attributed to specific physical or psychological causes;
- is always watchful, as though preparing for something bad to happen;
- lacks adult supervision;
- shows extremes of behavior—is overly compliant, an overachiever, or too responsible;
- comes to school/church/neighbor's home early, stays late, and does not want to go home.

The Parent

- shows little concern for the child, rarely responds to requests for information;
- denies the existence of (or blames the child for) the child's problems;
- affirms the use of harsh physical discipline;
- shows emotional immaturity, unmet emotional needs, low frustration tolerance leading to aggression, rigid thought and behavior patterns;
- sees the child as bad, worthless, burdensome, even just "different" (premature, handicapped);
- demands perfection or a level of physical or academic performance the child cannot achieve or has other unrealistic expectations;
- experiences a problem with alcohol or drugs;
- looks primarily to the child for care, attention, and satisfaction of emotional needs;
- is isolated or is experiencing a crisis or a series of crises;
- has a history of emotional deprivation as a child and negative past family life (parents abused as children have a six times greater chance of abusing their children without some intervention).

The Parent and Child

- rarely touch or look at each other;
- consider their relationship entirely negative;
- state that they do not like each other.

None of the above signs alone proves that child maltreatment is present in a family. Any of them may be found at one time or another. But when these signs appear repeatedly or in combination, they should trigger medical staff to take a closer look at the situation and to consider the possibility of abuse.

chairs to prevent crawling, and beating children with a variety of whips, canes, shovels, and paddles were typical parental behaviors. While the practice of severe beatings and torturous physical restraints lessened in the 18th century, the control of children was paramount, and corporal punishment reached its peak.

In 1874, Mary Ellen Wilson, an 8-year-old who was discovered chained, beaten, and starved by her adoptive parents, was the first child recognized as maltreated in the United States. Child abuse was not seen as an area of scientific and sociological inquiry, and there were no laws in the United States that addressed the abuse of children by their caretakers. It took the intervention of Henry Berg, the founder of the Society for the Prevention of Cruelty to Animals, to bring this case to trial.

A paper presented to the Medical Society of London in the late 19th century described "the case of a family with five children, four of whom had been treated for mysterious thickenings of the arm and leg bones." What would today most likely be recognized as evidence of child abuse was at that time dismissed as the early stages of rickets.[2]

In 1946, using diagnostic x-ray technology, physicians began to notice patterns of healed fractures in young children that could only have resulted from repeated blows. In an *American Journal of Roentgenology* article, radiologist John Caffey, M.D., labeled the pattern he found "Parent-Infant Traumatic Stress Syndrome" but made little mention of the possible causes of such fractures.[3] While he noted that they could have been inflicted on children by their parents, he added that "evidence was inadequate to prove or disprove this point."[2]

It was not until 1962, when pediatrician C. Henry Kempe, M.D., and his associates published their classic work, "The Battered Child Syndrome," in the *Journal of the American Medical Association* that battering and abuse became a focal point of public attention. In 1968, it was estimated that more children under the age of 5 died from parentally inflicted injuries than from tuberculosis, whooping cough, polio, measles, diabetes, rheumatic fever, and appendicitis combined. By the end of the 1960s, all 50 states had passed and instituted laws mandating the reporting of child abuse and neglect and had begun to take steps to treat abused children and their families.

What Do We See Today?

Child abuse happens. One in 50 Minnesota children were reported as abused last year, affecting all economic, racial, social, ethnic, and religious groups. For newborn children, maltreatment is the second leading cause of death after sudden infant death syndrome. For children under 5 years of age, child abuse and neglect is the second leading cause of death after accidents.

In the United States, an estimated 2.9 million children were reported to child protective service agencies in 1992. This figure represents an 8 percent increase over the number of reports filed in 1991. Experts attribute much of this increase to the economic stresses of rising poverty, unemployment, and work concerns; the effects of substance abuse; and greater awareness of and willingness to report child maltreatment.[4] Overall, child abuse reporting levels have increased 50 percent between 1985 and 1992.

In 1992, 17,988 reports of child abuse were made in Minnesota, involving 27,462 children—a 4 percent increase over 1991. In 1991, 13 Minnesota children died as a result of abuse. Nationwide in 1992, an estimated 1,261 child abuse- and neglect-related fatalities were reported to child protection agencies—an increase of 49 percent since 1985.

Clearly, the number of child maltreatment reports has increased dramatically in recent years, although most child abuse experts argue that there is actually less abuse today. Nonetheless, even with the high numbers of reports being made, investigations of reporting behavior indicate that as many as one-third of possible child abuse cases today remain unidentified and/or unreported.

More than half of maltreatment cases are perpetrated by parents or caretakers; another 35 percent to 40 percent are perpetrated

Child abuse and neglect are not isolated problems unrelated to the life of families and our society; the comforting thought that they afflict only someone else is an illusion that must be discarded.

—Jose D. Alfaro, Report to the New York Select Committee on Child Abuse, 1981

I thought I was the only kid this happened to. I was ashamed to admit it. I thought it was my fault. It's really good to know that other kids are going through the same thing and feel the same way I feel.

—Carol

by someone the child knows. During 1992 in Minnesota, 48 percent of child maltreatment reports were for physical abuse, 46 percent for neglect, 14 percent for sexual abuse, and 2 percent for emotional maltreatment.

Injuries and deaths are not the only consequences of child abuse and neglect. Some researchers believe that untreated abused children frequently grow up to be delinquents, murderers, and batterers. Abused children are frequently described as having a number of cognitive, emotional, and social difficulties. Recent research indicates that children who experience the most severe forms of maltreatment suffer significant in-

Signs of Specific Types of Child Maltreatment

Signs of Physical Abuse

CONSIDER THE POSSIBILITY OF PHYSICAL ABUSE WHEN THE CHILD SHOWS THESE PHYSICAL SYMPTOMS:

- unexplained burns, bites, bruises, broken bones, or black eyes (any fracture in a child less than 2 years or unexplained burn or bruise in a child under a year should be questioned);
- bruises in various stages of healing;
- bruises in unusual patterns or in clusters—especially if bilateral;
- immersion burns, indicating dunking in a hot liquid;
- cigarette, rope, or dry burns;
- lacerations of the lip, eye, or any portion of an infant's face, including gums;
- skeletal injuries such as metaphyseal or corner fractures of long bones, epiphyseal separation, periosteal elevation, or spiral fractures;
- head injuries such as absence of hair and/or hemorrhaging beneath the scalp due to vigorous hair pulling, subdural hemotomas, retinal hemorrhages or detachments, jaw and nasal fractures;
- internal injuries such as duodenal or jejunal hematomas, rupture of the inferior vena cava, or peritonitis.

... THE CHILD SHOWS THESE BEHAVIORAL SYMPTOMS:

- provides inconsistent explanations for injuries;
- seems frightened of his or her parent(s) and protests or cries when it is time to leave;
- shows extremes of behavior—shrinks at the approach of adults or is overly aggressive;
- shows regressive behavior, such as pants-wetting, thumb-sucking, frequent whining;
- reports injury by a parent or another adult caregiver.

... THE PARENT OR OTHER ADULT CAREGIVER:

- offers conflicting, unconvincing, or no explanation for the child's injury;
- describes the child as "evil," or in some other very negative way;
- uses harsh physical discipline with the child;
- has a history of abuse as a child.

Signs of Neglect

CONSIDER THE POSSIBILITY OF NEGLECT WHEN THE CHILD:

- is frequently absent from school;
- begs or steals food or money;
- lacks needed medical or dental care, immunizations, or glasses;
- is consistently dirty and has severe body odor or insect infestation;
- is sleepy or lethargic;
- lacks proper clothing for the weather;
- is not thriving in general;
- demonstrates anti-social behavior (aggression/disruption)
- excessively seeks out and "pesters" adults for attention and affection;
- abuses alcohol or other drugs.

... THE PARENT OR OTHER ADULT CAREGIVER:

- appears to be indifferent to the child;

tellectual deficits. Other studies find various social and emotional deficits, including communication problems, poor performance in school, and learning disabilities. As adults, abused children are also thought to have higher rates of drug and alcohol abuse, criminal behavior, and psychiatric disturbances.[5]

What Is Child Abuse?

Child abuse is defined as an injury or a pattern of injuries to a child that is nonaccidental. Child maltreatment includes nonaccidental physical injury, neglect, sexual abuse, and emotional abuse. Under 1993 Minnesota state law (Minnesota Statutes,

I was sexually abused by my stepfather when I was 9 years old. I was threatened by him constantly. He told me my mom would die if I told anyone. He also told me again and again, 'No one will believe you.'

—Deirdre

- seems apathetic or depressed;
- behaves irrationally or in a bizarre manner;
- is abusing alcohol or other drugs.

Signs of Sexual Abuse

CONSIDER THE POSSIBILITY OF SEXUAL ABUSE WHEN THE CHILD SHOWS THESE PHYSICAL SYMPTOMS:

- difficulty walking or sitting;
- reddened or traumatized genitalia (lacerations, abrasions, or bleeding);
- vaginal infections and discharges;
- pain on urination;
- unexplained gagging;
- becomes pregnant or contracts a sexually transmitted disease, particularly if under age 14;
- chronic stomachaches.

... THE CHILD SHOWS THESE BEHAVIORAL SYMPTOMS:

- bed-wetting;
- hyperactivity;
- altered activity level or eating or sleeping disturbances;
- learning problems;
- suddenly refuses to change for gym or to participate in physical activities;
- demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior such as compulsive "ritual" masturbation, precocious "sexual play," or excessive curiosity about sexual matters;
- chronic complaints about body aches and pains;
- separation anxiety;
- running away, depression, suicide attempts;
- starts fires (especially boys);
- reports sexual abuse by a parent or another adult caregiver.

... THE PARENT OR OTHER ADULT CAREGIVER:

- is unduly protective of the child and/or severely limits the child's contact with other children, especially those of the opposite sex;
- is secretive and isolated;
- describes marital difficulties involving family power struggles or sexual relations.

Signs of Emotional Maltreatment

CONSIDER THE POSSIBILITY OF EMOTIONAL MALTREATMENT WHEN THE CHILD:

- shows extremes in behavior, such as overly compliant or demanding behavior, extreme passivity or aggression;
- is either inappropriately adult (e.g., parenting other children) or inappropriately infantile (e.g., frequently rocking or head-banging);
- is delayed in physical or emotional development;
- has low self-esteem;
- has attempted suicide;
- reports a lack of attachment to the parent.

... THE PARENT OR OTHER ADULT CAREGIVER:

- constantly blames, belittles, or berates the child;
- holds unrealistic expectations for the child;
- is unconcerned about the child and refuses to consider offers of help for the child's problems;
- treats siblings unequally;
- overtly rejects the child.

When I finally reported the sexual abuse to the authorities, I was questioned by nine or 10 different people, all men, about the incidents. They kept asking me again and again if I was sure about this, if perhaps it could be a dream. I began to be afraid to tell everything because I felt it was my fault and that they didn't believe me. I felt shameful and I felt dirty and I was sure I had made this happen to me.

—Deirdre

section 626.556), maltreatment occurs if the child is under the age of 18 and has experienced:

Sexual abuse—the subjection of a child to sexual activity perpetrated by a person responsible for the child's care or by a person in a position of authority.

Physical abuse—a physical or mental injury or threatened injury, inflicted by a person responsible for the child's care.

Neglect—failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, or medical care when reasonably able to do so; failure to protect a child from conditions or actions that imminently and seriously endanger the child; or failure to take steps to ensure that a child is educated.

Mental injury—an injury to the psychological capacity or emotional stability of a child as evidenced by an observable or substantial impairment in the child's ability to function within a normal range of performance and behavior with due regard to the child's culture.

Threatened injury—statement, overt act, condition, or status that represents a substantial risk of physical or sexual abuse or mental injury.[6]

Role of the Medical Community

The medical community has three primary roles to play in addressing child maltreatment: recognizing, reporting, and preventing.

Recognizing

The medical community must be able to identify and report child maltreatment, which is often not obvious. For example, moderate rather than severe injuries comprise about 60 percent of the injuries resulting from physical abuse. Studies indicate that physician recognition of and response to potential child abuse are moderately affected by the ethnic status and socioeconomic status of the parent in addition to the severity of the injury to the child. As a result, many more low-income people and people of color are reported for neglect and physical abuse. While there are groups of parents at high risk, e.g., teen and single parents, the factors that lead to abuse can affect all families. Researchers consistently document that child maltreatment occurs with frequency in all communities regardless of family income, geography, ethnic background, or religion.

All children exhibit difficult behaviors related to normal childhood developmental stages. These behaviors, such as colic, trained night crying, separation anxiety, normal exploratory behavior, normal negativism, normal poor appetite, and toilet training resistance, provoke universal frustration in parents and other caretakers. Physicians should be familiar with the different stages of development and be available to give parents guidance and, as a result, help them avoid stress.

It is critical for medical professionals to recognize the signs of child maltreatment. The sidebars on pages 16 and 18-19 identify indicators that may alert doctors, nurses, physician assistants, medical office staff, or lab technicians to possible abuse.[7-9]

Reporting

Anyone may report abuse or neglect of a child. However, under Minnesota state law, certain people are *required* to report: professionals or their delegates who are engaged in the practice of the healing arts (including doctors, dentists, therapists, pharmacists, and nurses), members of the clergy, and those in social services, hospital administration, psychological or psychiatric treatment, child care, education, and law enforcement. The law requires mandated reporters to make a report if they know or have reason to believe a child is being neglected or abused or has been within the past three years.[6]

People reporting child abuse or neglect in good faith are immune from any civil liability. The reporter's name is confidential, accessible only upon consent of the reporter or by court order. Mandated reporters, required by law to report maltreatment, are guilty of a misdemeanor if they fail to file a report.

If uncertain whether or not a situation should be reported, medical professionals may call their local county social service agencies. The child protective service intake

Resources

Midwest Children's Resource Center
Dr. Carolyn Levitt, St. Paul
612/220-6750
• evaluation center
• training
• professional consulting line (24-hours per day—800/422-0879)
• shaken baby syndrome expertise and resource materials

Cornerhouse
Jocilyn Tilsen, Minneapolis
612/872-6225
• evaluation center • training

University Consortium on Child, Youth, and Families
Marti Farrell Erickson, Ph.D., Minneapolis
612/626-1212
• evaluation expertise
• training
• computer resource database
• program evaluation

Minnesota Committee for Prevention of Child Abuse
Larry Mens, St. Paul
612/641-1568
• resource center • training

Pacer, Let's Prevent Abuse Program
Deb Jones, L.P.N., Minneapolis
612/827-2966
• resource center for special needs children • training

Black, Indian, Hispanic and Asian Women in Action (BIHA)
Alice Lynch, Minneapolis
612/870-1193
• referral linkage to agencies serving communities of color
• training

Center for Child Abuse Prevention and Treatment
Barb Klatt, M.S.W., Minneapolis
612/699-4102
• training

worker will help determine whether a report should be made based on the information provided. Reports may also be made directly to the local law enforcement agency—especially if the child is thought to be in imminent danger or abandoned. Law enforcement officers can remove a minor from a threatening environment to protect the child.

What child protection needs to know: When a report of abuse is made to child protection, intake workers will ask for information to assist them in identifying the family, evaluating the problem, and responding quickly and appropriately. A medical staff person would be asked:

• reporter's name and phone number;
• what happened to the child and when;
• where the child is now;
• the names and addresses of the parents or caretakers;
• first-hand knowledge the reporter may have about the child or family.

A mandated reporter must file a written report within 72 hours of a verbal report. After receiving this information, child protection and/or law enforcement will evaluate the information to determine whether or not to conduct an interview with the child and parent or caretaker. If a case is opened, an assessment is made to determine whether abuse or neglect has occurred. That information must be presented to a judge before a family can be separated and treatment or parenting education can be mandated. The reporter can request from the local child protection office a summary of the disposition of the report, which would include the agency's determinations, the nature of the maltreatment, services provided, and the name of the assessment worker.

Because Minnesota is a county-based state, all child maltreatment statutes are interpreted by the county attorney. Child protective service offices are also funded by the counties. Thus, the threshold of abuse that would merit a maltreatment determination varies from county to county. Smaller counties often are able to intervene much earlier. Since Minnesota has no central registry of reports, it is quite possible that abusive families move frequently and "doc-

Let us put our minds together and see what kind of life we can make for our children.

–Sitting Bull

tor shop" so that a child maltreatment case cannot be opened.

In larger medical facilities, referral to a child abuse team may be required when maltreatment is suspected. For more isolated medical staff, the Midwest Children's Resource Center in St. Paul staffs a 24-hour professional consultation line to help answer questions (800/422-0879).

Preventing

Practitioners from many branches of medicine have played a leading role in increasing awareness and identification of child maltreatment during the past two decades. As concern shifts from the identification and remediation to prevention of child abuse, the medical sector has an equally crucial role to play.[10]

On the most basic level, activities to protect and promote the health of children and their parents can help prevent child maltreatment. Prenatal, birth, and perinatal complications and health and developmental problems in infancy and early childhood appear to heighten the risk of child maltreatment. Prenatal, well-child, and adult health care visits can provide opportunities for reducing the potency of these risks.

I don't see abuse in my private practice. It doesn't happen in middle-class neighborhoods.

—interview response, U.S. physician

Health care providers are among the only professionals who have regular contact with children during the critical years from birth to age 5. Given the high morbidity and mortality rates from child abuse and neglect among this young population, the medical system is uniquely placed to screen children routinely for non-accidental injuries. By identifying the signs of early family dysfunction, health care providers can act as "brokers," connecting families and children with community services that reinforce positive parenting, increase individual coping skills, and help strengthen families.

Many different health and mental health care providers interact with children and their parents at various times throughout childhood—pediatricians, family physicians, obstetricians, psychiatrists, nurses, emergency and maternity ward staff, radiologists, neurologists, orthopedic surgeons, school health personnel, public health nurses, sports medicine practitioners, etc. Although each specialist may provide distinct medical services to children and their parents, all health care providers share the responsibility to prevent child abuse and neglect by identifying and responding to the early signs of parent-child problems.

Training: In order to carry out their preventive role successfully, all health professionals should receive medical training that emphasizes a broad approach to the child and that imparts the relevant skills for observing and assessing families for the early signs of dysfunction or abuse. This training should also include information about the links between child maltreatment, domestic violence, and substance abuse (see "Chemical Abuse and Family Violence in Minnesota," page 24). In Minnesota, several organizations offer such training—see the sidebar on page 21.

Prenatal and early childhood health care: Researchers have found rates of maltreatment three to eight times higher among premature and unhealthy newborns. The provision of adequate prenatal and early childhood health care—to help prevent poor pregnancy outcomes, neonatal complications, and childhood health and developmental problems—can reduce the incidence of problems that increase the risk of maltreatment.

Family-centered birthing and perinatal coaching: By strengthening the early, positive bonding between parents and their children, the breakdown of parent-child relationships that can lead to abuse and neglect may be prevented. Anecdotal and research evidence point to the period immediately following birth as a critical time for attachment between new parents and their infants. Retrospective studies show that babies who are separated from their mothers following birth, because of prematurity or other complications, are disproportionately abused or fail to thrive during childhood.

Home health visitor programs: Support, education, and links to community resources are important for new parents. The period immediately following the birth of a child is a time of stress for new parents and a period

in which initial interactions can establish lasting positive—or negative—behavioral patterns between parents and their children. The National Committee to Prevent Child Abuse has begun a nationwide initiative called Healthy Families America based on the Healthy Start Program in Hawaii, which has virtually eliminated physical abuse and neglect in the high-risk families that volunteer to take part in the program. The program calls for a close working partnership between the medical community and home visitation programs using both professional and trained lay volunteers to provide support, training, and monitoring for new parents.

Support programs for parents of special needs children: Parents of children with special health and developmental needs may require support services to prevent stress and parent-child disruptions that can lead to abuse. Programs to provide support, assistance, and training may alleviate the risk of abuse and neglect.

Awareness and ties to community resources: Helping parents and children talk about maltreatment, better ways to communicate, and resources within their own communities is important. Many parents and children are desperately seeking someone to give them permission to talk about these issues. Simple things like posters on a wall, a resource rack with child maltreatment and parenting information, or a resource table with brochures from community organizations may encourage patients to discuss these topics with medical staff. Additionally, these resources can help to prevent maltreatment. For example, researchers have found that the placement of a series of "Behavior Management Cards" in doctors' offices increases patient knowledge of parenting skills and reduces their risk of abusive behavior (available through the Minnesota Committee for Prevention of Child Abuse, 612/641-1568).

Partnerships within the community: Leadership from the medical field is necessary to facilitate partnerships within the community. In Minnesota, many doctors are members of county child protection teams, which consult on specific child abuse cases. Many other medical professionals are part of the Children's Trust Fund's county-based child abuse prevention councils. Still others serve as board members or volunteers for agencies serving parents and children.

All sectors of the community must work together to put an end to child abuse and neglect. Recognizing, reporting, and preventing are tools the medical community can use to solve the pervasive societal problem of child maltreatment. MM

Larry Mens is executive director of the Minnesota Committee for Prevention of Child Abuse in St. Paul, Minnesota.

The effort to help maltreated children, in the end, united the forces of compassion and common sense in our society.

—Jose D. Alfaro, Report to the New York Select Committee on Child Abuse, 1981

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Chemical Abuse and Family Violence in Minnesota

Chemical abuse is not often discussed in the context of domestic violence, but research shows that the two problems often go hand-in-hand.

Cynthia Turnure, Ph.D., and Pamela Young

Editor's Note: *Stopping family violence has been a priority of the Minnesota Medical Association and the American Medical Association for the past two years. We have looked at ways physicians can identify abusive situations, worked with coalitions to raise general awareness, and worked within our organization to raise physicians' awareness. Yet none of the literature published by the MMA or the AMA provides information on the single factor most commonly associated with family violence and child abuse—alcohol use and abuse. This article outlines some of the evidence linking alcohol and family violence and emphasizes something we often prefer to ignore: alcohol use and abuse are potentially dangerous to the user, as well as to his or her family.*

–Barbara P. Yawn, M.D., M.Sc., series editor

A 1990 tragedy in Minnesota raised troubling questions about the connections between chemical dependency and domestic violence. Sunfish Lake physician Douglas Simmons, M.D., shot and killed his wife, Linda, in front of their two young sons. Just two days before the murder, Linda had called police to her home for the first time. She said that her husband was intoxicated and throwing dishes around, and she stated, "He's been drinking. He scares me."

Simmons warned the officers, "If I was a police officer, I wouldn't leave me here with that woman." The officers stated that there was no evidence of physical violence and took Simmons to a detoxification center. However, since Simmons had entered voluntarily, his attorney was able to obtain a judge's order for his release within a few hours. After making his way back to his suburban home, Simmons continued to drink and on Sunday evening called a friend to report the murder.

The high correlation between alcohol and drug abuse and various forms of family violence has been well-documented in the research literature:

- 25% to 80% of men who have assaulted their partners were drinking at the time, and controlled studies have shown that husbands in abusive relationships score higher on alcoholism screening tests than those in nonabusive relationships;[1]
- 30% to 84% of child abuse and neglect cases occur in families where alcohol and/or drug abuse is also present;[1]
- 40% to 70% of chemically dependent women in treatment have a family history of incest; 65% of incest offenders were drinking at the time of their offense.[1]

While the extent of these problems in Minnesota is less well-known, this article summarizes the current data we have on these problems in Minnesota and highlights issues that must be addressed if the cycles of family violence and chemical abuse are to be arrested.

Scope of the Problem in Minnesota

In the 1989 Minnesota Student Survey, one-fourth of all high school students reported family alcohol or drug problems, and students from families with substance abuse problems were two to three times as likely to have been beaten or sexually abused by a family member.[2]

In 1991, there were 17,480 reports of child maltreatment in Minnesota. Actual maltreatment was found in 40% of the cases, involving 10,224 children. Alcohol and drug abuse were identified as problems for one-fifth of the perpetrators of physical and sexual abuse and one-third of the perpetrators of child neglect. Alcohol abuse was the most frequent problem associated with perpetrators of all types of child maltreatment in Minnesota.[3]

According to statistics from the Minnesota Department of Corrections,[4] in fiscal year 1993 law enforcement was reportedly called to more than 13,000 domestic violence incidents (these were the ones reported and documented), and emergency shelter was provided to 5,629 women and 5,684 children. The Department of Corrections estimated that the actual number of domes-

tic violence incidents may be as many as 132,000 each year. Of 355 women assessed for chemical use by one Minnesota women's alcohol and drug treatment program in 1987, 43.7 percent had been physically or sexually assaulted as an adult.[5]

The Minnesota Child Mortality Review Panel reviews deaths of Minnesota children in which the family was receiving public social services. The panel's latest report identified chemical abuse as the single most common factor in child deaths reviewed by the panel in recent years.[6]

It is clear from the data that these problems affect many Minnesota families—from all socioeconomic levels—either directly or indirectly.

Recommendations from Battered Women

In 1989 and 1990, the Minnesota Coalition for Battered Women[5] hosted a series of public forums around the state. Women were invited to describe their own experiences as battered women who had not only survived violence in their lives, but had also struggled with their own or their partner's chemical abuse. Summary recommendations included the following:

Women's safety must be the first consideration. For some women, escaping the violence will have to come before addressing her or her abuser's chemical use. It is important never to attribute the abuser's violence to the battered women's chemical use. Battered women's advocates (including physicians) should have information about chemical abuse and learn the skills to provide advocacy for abused, chemically dependent women. Programs should provide women with information that will help them to make good choices for themselves. Culturally sensitive programs are best suited to provide help in coping with both chemical dependency and battering.

The project developed a manual to assist alcohol and drug counselors and battered women's advocates in implementing these recommendations. The manual is available from the Minnesota Coalition for Battered Women, 1619 Dayton, Suite 303, St. Paul, Minnesota 55104.

What Can Physicians and Others Do?

To better address the issues of chemical abuse and family violence, physicians and other health care professionals must:

- acknowledge the correlation between alcohol and family violence;
- routinely screen for abuse;
- ask about alcohol use; and
- be alert for red flags.

Physicians and other health care providers must recognize the correlation between alcohol and family violence and the signs and symptoms so that they can identify problems early and make appropriate referrals. This will require more training for primary care physicians and other professionals, such as nurses, social workers, law enforcement personnel, judges, and chemical dependency counselors, who are in a position to intervene in such cases.

Additional routine screens for abuse must be included with general health assessment questions. Health care providers should ask whether patients have a family history of alcohol and drug abuse or family violence and whether the patient is in a relationship with someone who has alcohol or drug use problems. Additional questions trained professionals may include in their screens for risk assessment are: Have you ever been annoyed by comments about your drinking? Have friends and family members expressed worry about your drinking? Have you ever tried to cut down?

Better information must be available to physicians, providers, and patients on appropriate services, such as chemical dependency assessments and treatments, battered women's programs, legal services, client advocacy, child care, transportation, and crisis services (see pages 29 and 30 for a resource guide). More public information and training efforts are needed to make existing resources more accessible.

Better coordination is needed among the various professionals and programs involved, such as social services, chemical dependency treatment programs, battered women and sexual assault resources, law enforcement, the courts, and corrections, so that cases do not fall through the cracks—as happens all too often now. Each discipline needs to understand and recognize the services appropriately performed by the others and help coordinate all necessary services to meet the client's needs. Differences in philosophy or concerns about "turf" cannot be allowed to prevent women from receiving necessary services.

More integrated treatment approaches are needed to deal with the various issues involved in chemical abuse and family violence at the same time rather than sequentially. Minnesota has developed distinct treatment systems for each of these problems, but there is growing evidence that treating these problems separately may not be as effective as treating them together. The traditional "Minnesota model" of chemical dependency treatment, for example, relies on the concept of powerlessness, which contradicts the treatment philosophy of most battered women's programs, which stress empowerment. More integrated approaches are needed to deal with issues common to these problems, such as family dysfunction, shame, boundary inadequacy, denial, and depression. Sound linkages between existing treatment programs, such as designated staff liaisons, joint training, and common groups, are essential to meet the needs of families affected by both chemical abuse and family violence.

Finally, efforts to prevent both chemical abuse and family violence in our society must be strongly supported. Minnesota has taken some good initial steps in chemical abuse and violence prevention, as summarized in recent reports of the Chemical Abuse Prevention Resource Council, the Office of Drug Policy and Violence Prevention, and the MMA's Stop the Violence Campaign. However, much more is needed if we are to truly stop the devastation caused by these problems and

reduce the enormous cost to our health care, criminal justice, and other systems. One of the first steps must be recognition of substance use and abuse, particularly alcohol abuse. MM

Cynthia Turnure is director and Pamela Young is a women's planner with the Chemical Dependency Program Division of the Minnesota Department of Human Services.

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Lines of Defense: Domestic Violence Awareness Month

Physicians must join the battle against family violence—a war whose front line lies just behind America's front doors.

Robert E. McAfee, M.D.

America is a nation at war, and the struggle is as close as our own living rooms. Every day we read about gangs battling on our urban streets, the pernicious hold drugs still have on many of our youth, and the continuing fight against AIDS. We are less likely, however, to read about the war played out within the American family, where the front lines lie hidden behind the front doors of our communities. This is the battlefield of domestic violence, where the casualties are enormous and the heroes far too few.

It has been said that heroes are those who do what they can. With so much that physicians can do in this crisis, the hour for quiet heroism is upon us. October is Domestic Violence Awareness Month, a chance for us to take stock of our efforts.

By the time you have finished reading this sentence, another woman in the United States will have been beaten, battered, and bruised by someone she knows. Every 12 seconds, 24 hours a day, 365 days a year, a woman is punched, kicked, slapped—or worse.

The damage does not stop, however, with the lives and bodies of women. Domestic violence targets all of the most vulnerable among us, including small children and the frail elderly. Two thousand American children are beaten and starved to death every year, and millions more suffer the horrific effects of ongoing abuse and neglect. It is hard to measure how many millions more victims are ignored or overlooked, because physicians fail to properly identify *as many as 95 percent of the victims of domestic violence.*

The security of a physician's office may be the only sanctuary the patient can find in a personal hell of violence and neglect. We have a responsibility to help stem this growing American epidemic.

We must begin with our own awareness of violence in the family. When physicians examine patients with cuts and bruises and broken arms, we may actually be treating victims of abuse. With a problem as prevalent as domestic violence, the AMA's guidelines for diagnosis and treatment recommend *routine* screening in the primary care setting. We must be on the lookout, because AMA research shows that 80 percent of Americans feel they could tell a physician if they had been either a victim or a perpetrator of family violence.

In 1990, the AMA formed the National Coalition of Physicians Against Family Violence, now more than 6,000 members strong. The coalition keeps physicians informed about resources, model programs, speakers, and public education materials. Participants receive the AMA Diagnostic and Treatment Guidelines on child and elder abuse and domestic violence, as well as patient materials bearing the message, "When you break the silence, you begin the cure."

It will take more than openness or good medicine to make the cure complete, however. Physicians should become familiar with the range of resources in the community: shelters, legal advocacy, counseling, support groups, and crisis hot lines (see resource guide, pages 29-30). Look also to the grassroots efforts of your own medical association, where physicians like you have already taken this issue to heart. To turn the tide in a war of this magnitude will require attacking on as many fronts as possible. It is going to take lawyers, judges, and the police; concerned citizens and local communities; all of us engaged in health care; and the victims themselves—all working together.

To do *your* share to recognize and treat victims of domestic violence, just keep your professional RADAR turned on:

- Remember to screen your patients about violence.
- Ask questions such as: "At any time, has a partner hit, kicked, or otherwise hurt or frightened you?"
- Document your findings. Information in the patient's chart about "suspected domestic violence" can serve a valuable function in court should the patient seek legal action. A physician's documentation validates the victim's allegations.
- Assess your patient's safety. Is it safe to go home? Find out if any weapons are kept in the house, if the children are in danger, and if violence is escalating.
- Review options with your patient. Know about referral options.

As physicians, as citizens, as parents, as sons and daughters, we must

work together to end the violence, beginning now with Domestic Violence Awareness Month. MM

Robert McAfee is president of the American Medical Association and a surgeon practicing in South Portland, Maine. He will be speaking in Bloomington at the November 4 conference, "Broken Bones and Black Eyes: Can You Identify Abuse? How Will You Respond?" For more information, contact Cathy Graci at the Ramsey County Medical Society, 800/999-1875 or 612/362-3704.

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Diagnostic and Treatment Guide for Domestic Violence

The following information is drawn from the AMA "Diagnostic and Treatment Guidelines on Domestic Violence" and information provided by Susan M. Hadley, M.P.H., executive director of WomanKind, Fairview Health System.

How Do You Identify Family Violence?

- Routinely screen for abuse.
- Ask the right questions.
- Be alert for red flags.

ASK THE RIGHT QUESTIONS

In case of injury, interview the patient alone and ask a direct question:

- Did someone hurt you? Did you get these injuries by being hit? In case of anxiety or symptoms of depression or a suicide attempt, ask: What seems most overwhelming in your life right now?

Follow up with the questions suggested for a routine assessment.

In a routine assessment, begin by explaining that you ask all patients these questions as part of their medical history.

- Are you (have you ever been) in a relationship in which you felt you were badly treated? In what ways?
- Has your partner ever prevented you from leaving the house, seeing friends, getting a job, or continuing your education?
- Does your partner try to control your behavior? In what ways?
- We all fight at home. What happens when you and your partner fight or disagree?
- Has your partner ever threatened you?
- Has your partner ever destroyed things that you cared about?
- Has your partner ever threatened or abused your children?
- Has your partner ever forced you to have sex when you didn't want to? Is it OK to say no?
- You mentioned your partner uses drugs/alcohol. How does he act when he is drinking or on drugs? Is he ever verbally or physically abusive?
- Has your partner ever pushed, shoved, grabbed, hit, or slapped you?
- Do you feel that you have to "walk on eggshells" around your partner?
- Have you ever been hit while you were pregnant?
- Do you ever feel afraid of your partner?
- Do you have guns in your home? Has your partner ever threatened to use them when he was angry?

BE ALERT FOR RED FLAGS

- Suspect domestic abuse if the patient has attempted suicide or shows symptoms of depression or anxiety. Mental health problems such as panic attacks, sleeplessness, suicidal feelings, alcohol or drug abuse, post-traumatic stress reactions, feelings of isolation, and inability to cope may be signs of domestic abuse.
- Inquire more closely if the patient denies abuse but has unexplained injuries or if the explanation of how an injury occurred seems implausible. Be alert for discrepancies between the patient's story and her injuries. Look for bruises, lacerations, fractures, or multiple injuries in various stages of healing.
- Common injuries for battered women are in the face, back of the head, chest, breasts, abdomen, and genitals. There may be burns, whip-like bruises, choke marks on the neck and grab marks on the upper arms. Battery to pregnant women is often aimed at the breasts or abdomen.
- Patient may avoid eye contact, seem agitated, or appear more upset than her injuries would warrant.
- Repeat visits to the emergency room or physician's office with chronic injuries or vague complaints may be a cry for help.
- Be suspicious of considerable delays in seeking treatment. The victim may not be able to go for help until the abuser leaves the house.
- An abusive partner may accompany the patient and insist on staying close. He may be overly solicitous and eager to explain the injury and answer all questions for her.

What If You Discover or Suspect Violence?

- Listen to her. Believe her.
- Acknowledge that violence is wrong. Tell her that family violence is a crime. Nobody deserves to be hit.
- Do not pass judgment on the patient or the person who has hurt her.
- Assure her that help is available both for her and her abuser.
- Tell her she can take these steps to stop the abuse:
  - –join a support group.
  - –stay at an emergency shelter.
  - –seek legal remedies or advice.
  - –seek counseling.
- Ask: Are you safe right now? Where will you go after you leave my office?
- Set up a follow-up appointment.
- Accept the patient's timetable. Resist the impulse to go for a quick fix. Victims may need time before they are ready to accept help. Leave the door open.
- Report abuse of children or vulnerable adults to the proper authorities. Consult your local telephone directory for the crisis numbers for adult protection and child abuse/protection in your county. Keep these numbers easily available.
- Document abuse in the medical record. Include physical findings, patient's history and statements, and photographs of the injuries.
- Refer the patient to a specific local source of further help. Her first step may be a support group.

continued

Domestic Violence Referral Numbers

General

DOMESTIC VIOLENCE 24-HOUR METRO CRISIS LINE: 612/646-0994

A 24-hour domestic violence line for counseling and identifying a shelter. Referrals can be made for legal services and to culturally specific programs.

THE INITIATIVE FOR VIOLENCE-FREE FAMILIES AND COMMUNITIES IN RAMSEY COUNTY: 612/266-2404

A community-based effort of more than 300 individuals and 100 organizations working together to end violence in families and communities. While the focus is on Ramsey County, a number of the 11 action teams welcome participation from the broader Twin Cities community.

MINNESOTA OFFICE OF DRUG POLICY AND VIOLENCE PREVENTION: 612/297-7311

Information clearinghouse and referral source for educational materials. Provides technical assistance to community groups working on violence prevention issues.

MINNESOTA PREVENTION RESOURCE CENTER: 612/427-5310

A statewide clearinghouse for alcohol and other drug abuse materials, including fact sheets on alcohol-related sexual assault and violence.

UNITED WAY FIRST CALL FOR HELP: 612/335-5000

A free, 24-hour information and referral service to more than 2,200 community organizations, including many that focus on preventing violence and/or provide services to victims of violence.

Battered Women

MINNESOTA COALITION FOR BATTERED WOMEN
612/646-0994, 24-hour crisis line.
612/646-6177, coalition office.
612/646-6177, information and local referrals.

The coalition will put you in touch with emergency shelters, advocacy services, and legal advocacy resources for battered women in communities throughout Minnesota. Some focus on specific populations, such as Hispanic or Native American women as well as women with disabilities. Know the name of the program in your area and keep the phone number handy to give patients who need emergency shelter or support. All the programs are free, confidential, and available 24 hours a day.

Ask your local programs for brochures to put in your examining rooms, where women may read them in private.

Elder Abuse

SENIOR LINKAGE LINE: 800/333-2433

Call to find out the services available in your local community.

Sexual Abuse

MINNESOTA COALITION AGAINST SEXUAL ASSAULT: 612/872-7734 or 800/964-8847

The coalition provides education and referrals for advocacy. Call the coalition to find out the phone number of the crisis line for sexual violence in your area.

Child Abuse

Call your county child protection agency to report suspected abuse and to find out about the crisis nurseries and support services in your area. Keep these numbers handy. Ask for brochures to keep in your examining rooms.

MINNESOTA CHAPTER, NATIONAL COMMITTEE FOR THE PREVENTION OF CHILD ABUSE: 612/641-1568

This agency provides educational programs and information on ways to detect and prevent child abuse.

MINNEAPOLIS CRISIS NURSERY: 612/824-8000

This program offers crisis intervention and resource referral for families regarding child abuse prevention. It provides emergency care for children newborn through 6 years to prevent neglect and abuse.

Same-Sex Partner Abuse

DOMESTIC VIOLENCE PROGRAM—GAY & LESBIAN COMMUNITY ACTION COUNCIL: 612/822-0127 or 800/800-0350

GAY & LESBIAN HELPLINE: 612/822-8661 or 800/800-0907

Southeast Asian Victims

COMMUNITY UNIVERSITY HEALTH CARE CENTER: 612/627-4774

The Community University Health Care Center provides counseling and social services in Southeast Asian languages.

Crime Victims

Call 800/247-0390 for 24-hour referral services for crime victims.

Prostitution and Pornography Victims

WHISPER: 612/644-6301

PRIDE: 612/729-0340

These programs provide support services for women abused in prostitution and pornography.

Help for Men and Women Who Abuse

If a patient confides that he or she is violent to a child or spouse or elderly parent, tell him or her: "It's never OK to hit someone; in fact, it's a crime. If you are hitting someone you love, stop it and get help. If you hurt family members, you are teaching your children to be violent."

Refer the patient to Parents Anonymous or to a domestic abuse intervention project. Call the Minnesota Coalition for Battered Women for the name of an intervention project for abusers in your area. Two of the projects in Minnesota that provide education and counseling groups for abusers are listed below.

DOMESTIC ABUSE PROJECT: 612/874-7063

DOMESTIC ABUSE INTERVENTION PROJECT: 218/722-4134

Call for information about your local chapter of Parents Anonymous. Support group meetings for parents are free and child care is provided.

PARENTS ANONYMOUS OF MINNESOTA: 612/487-2111

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*Additional price lists are available at a nominal fee. These fees are applicable toward the lease or purchase of a new vehicle.

Announcements

Primaries Narrow the Field

Gov. Carlson's win in the IR primary election was welcome news for physicians. The MMA sent a letter to all MMA members urging them to vote for Carlson in the primary. Unfortunately, Scott Wright, M.D., a Mayo fellow in cardiology, lost his bid to be the IR candidate for the state Senate seat vacated by Sen. Duane Benson (IR-Lanesboro). Benson left the Legislature to become executive director of the Minnesota Business Partnership. Richard Mulder, M.D., a family physician in Ivanhoe, did not face a primary challenge. He is the endorsed IR candidate in District 21B for the Minnesota House of Representatives, challenging the DFL incumbent, Andy Steensma. Mary Hill Smith, wife of Andrew J.K. Smith, M.D., president of the MMA, will be on the ballot as a District 7 candidate for the Hennepin County Board. She came in second in the primary with 30 percent of the vote. The top two candidates will be on the November ballot.

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Medical/Civil Liberties Forum

The Minnesota Civil Liberties Union Foundation presents the first annual Medical/Civil Liberties Forum Tuesday, November 15, at 7:30 p.m. at the St. Paul College Club, 990 Summit Avenue in St. Paul. Guest speaker Steven H. Miles, M.D., a geriatrician and medical ethicist, will speak on civil liberties and end-of-life care. The registration fee is $50, of which $45 is a charitable contribution. Mail your registration to the Minnesota Civil Liberties Union Foundation, 1021 West Broadway, Minneapolis, MN 55411. The telephone number is 612/522-2423.

The Monitor

News For Minnesota Physicians

Health System Reform Hangs by a Thread

As *The Monitor* goes to press, the future looks bleak for Clinton's health system reform efforts, but there's still a chance some kind of health bill will pass—possibly a watered-down version of the reform bill, or legislation targeting low-income children.

During the congressional recess, the MMA met with Minnesota representatives to discuss concerns about national health system reform. MMA leaders and staff met with Reps. Collin Peterson, D-7th, Jim Ramstad, R-3rd, and David Minge, D-2nd, to talk about antitrust, tort reform, insurance reform, and the Patient Protection Act.

Minge has signed on to the bipartisan House bill, supported by the AMA, which calls for insurance reforms and subsidies funded by cuts in Medicare and Medicaid growth. It is unlikely, however, that the House will take up any health system reform bill unless the Senate passes one first. The comprehensive universal coverage bill drafted by House Majority Leader Richard Gephardt, D-Mo., appears to be DOA. The AMA opposed this bill mainly because it would create a new Medicare Part C program.

The Senate is a house divided. Senate Majority Leader George Mitchell, D-Maine, is trying to patch together a proposal that would be a compromise between his own proposal and the bipartisan mainstream coalition's plan calling for market-based insurance reform and deficit reduction. Sen. David Durenberger, R-Minn., is a leader of the mainstream coalition and a strong opponent of an employer mandate. The mainstream proposal relies on Medicare and Medicaid cuts to control spending. This plan could be doomed by opposition from both the right and the left.

A group of Senate republicans reportedly have said they would oppose any efforts to pass health reform legislation in the little time remaining.

Senate liberals, including Sen. Paul Wellstone, D-Minn., would rather see no reform bill than a version as scaled back as the mainstream coalition proposal, which Wellstone calls an "unworkable retreat." They are pinning their hopes instead on a plan to provide health insurance for children in low-income families. "It gets very hard to vote against children," said Sen. Jay Rockefeller, D-W.Va.

Led by Sen. Tom Harkin, D-Iowa, and Wellstone, a group of senators are drafting a bill that would provide subsidies on a sliding scale to buy insurance for children whose families earn between 300 percent and 400 percent of the federal poverty level. The children would receive the same federal health benefits package enjoyed by members of Congress. Funding would come mainly from a $1 per pack increase in the cigarette tax, plus a possible increase in Part B premiums for Medicare beneficiaries in the highest income bracket. The plan, which is still on the drawing board, may also include home-based long-term care, tax deductions for the self-employed, and insurance reforms. • • • • •

HCMS and AMA Work to End Abuse in the Workplace

Minnesota is in the forefront of an up-and-coming national issue—creating a violence-free medical workplace.

The Hennepin County Medical Society has been working for several years with Respond 2, Inc., a private consulting firm, to develop programs to end violence and abuse. Now the HCMS Abuse Prevention Project will help develop a national model to be used by the American Medical Association (AMA).

"Abuse in a medical setting can have serious consequences for patient care," said Alison Coulter-Knoff, M.D., chair of the HCMS Abuse Prevention Project. "If an abused woman sees the hospital staff behaving disrespectfully toward one another, she's not likely to divulge what's going on in her own life because she's not in a safe environment. Physicians must be role models, demonstrating respectful interactions that don't revolve around power and control."

Local concerns vaulted to national prominence in 1993, when the Minnesota delegation to the AMA House of Delegates introduced a resolution calling on the AMA to review studies of abuse in the medical workplace and to develop guidelines to help end abuse. The AMA House adopted the resolution, and in 1994, adopted a report calling on the AMA to work with the Hennepin County Medical Society to develop those guidelines.

Now the HCMS/AMA project is moving forward. "The guidelines will be based on experience as well as research," said Deborah Anderson, president of Respond 2. The HCMS project plans to set up model "abuse-free" environments in several different settings—hospitals, fee-for-service clinics, teaching clinics, HMO clinics, a rural clinic, and possibly out-of-state settings. Then HCMS, the AMA, and representatives of the various sites will write guidelines based partially upon the experiences of the model sites.

The five-step process to develop the guidelines for an abuse-free medical workplace is outlined below.

The first step in the process is to build a team. It is critical that everyone on the medical staff be involved: executives, physicians, nurses, administrators, support staff, cleaning staff. "If leadership isn't involved, there's trouble," said Anderson.

Coulter-Knoff added that "the two most important factors in success are the ongoing support of the CEO, and the employees' willingness to accept change. Change can be very threatening."

The second step is to conduct a survey. The survey asks what kind of behavior the staff considers abusive. This is a key question, according to Coulter-Knoff. You have to be able to recognize abuse before you can end it. Nobody wants to be seen as a victim. There's a tendency to think that the way a person is treated is the norm. The survey also asks: Who is seen as abusive? What kind of intervention would help? How do abusive relationships affect the functioning of this organization? What keeps people from speaking up? The answers serve as a road map for further action. The team decides: where do we go from here?

The third step is for the team to design intervention strategies. "Abuse is based on power and control," said Coulter-Knoff. "It would be counterproductive for us to go in, take control, and tell groups what we see as their problem. We want to empower them to come up with their own solutions." Some examples of team-designed interventions are educational programs and materials, training programs, role playing, newsletters, and staff/employee support programs. People who believe they have been treated disrespectfully are encouraged to explain this to their abuser in a group setting. This helps people to recognize abuse and to begin to change their behavior.

The fourth step is to measure the outcomes of the team's work. The survey asks: Have working relationships improved? Are relationship

How Prevalent Is Violence in the Medical Workplace?

• • • • • SURVEYS CONDUCTED BY Respond 2, Inc., a consulting firm that works with Minneapolis hospitals, revealed some disturbing statistics.

A survey of health care workers found that physicians were seen as the most abusive by 80 percent of those surveyed, even by other physicians.

Abusive behavior is more common in the workplace than in the home, according to a 1992 study published in the *Journal of the American Medical Association (JAMA)*. The study, a major part of which was conducted in Twin Cities hospitals, found that about 65 percent of the workers said they experienced or observed abusive behavior in their workplace at least once a month, while 60 percent reported such abuse at home.

The prevalence of violence among physicians might be traced back to the way they are trained in medical school, suggested Deborah Anderson, president of Respond 2, Inc. Forty-six percent of medical students reported being abused while they were in medical school in a survey published in *JAMA* in 1990.

There are also statistics that offer hope for an "abuse-free" future. More than 95 percent of the physicians surveyed believe abusive people can change their behavior.

problems identified early? Do people feel better about going to work? One way to measure how much people's vision has broadened is to compare their definition of abuse at this point with their answer in the first survey. Do they now see behavior as disrespectful or abusive that before seemed normal because it was so prevalent?

The fifth step is to write policy and guidelines for an abuse-free medical workplace. The AMA will disseminate these guidelines throughout the nation.

Ending abuse in the medical workplace is an important step toward ending violence in society. "Abuse definitely affects patient care," said Coulter Knoff. "If we don't treat each other well, we can't treat our patients well. Abuse prevention has to start where you live, with the people whose lives you touch." • • • • •

Program for Impaired Health Care Workers Is Available

The state's new Health Professional Services Program (HPSP) is now up and running. This program was designed by the 1994 Legislature as an alternative to disciplinary action for licensed health care professionals who are unable to practice with reasonable skill and safety. The illnesses this program addresses are physical, mental, or psychological conditions, including chemical abuse and/or dependency.

The HPSP manager, John Loughren, stresses that licensed health care workers may report to the program even if they just suspect their ability to practice may be impaired. They don't have to be sure they are impaired and need monitoring. The program wants to cast its net wide, offering its services to any health care professional who might need it, and the language in HPSP's brochure reflects that desire.

It is important to note, however, that once providers are in this program, they cannot leave until the terms of their program participation agreement are fulfilled—unless they report to their licensing board. They can't just drop out and go about their business if they don't like the program. This is a serious alternative to disciplinary action.

The HPSP will develop individual program participation agreements tailored to the participant's illness. Agreements may include a treatment or continuing care plan, practice limitations, body fluid screening, and reporting requirements. The program may refer participants for professional evaluation or treatment. Participants are responsible for paying for the costs of evaluation, treatment, and drug screens. HPSP will monitor compliance with participation agreements. Failure to comply with the agreement would lead to dismissal from the program and referral to the licensing board.

Regulated health professionals may fulfill their obligation to report a health care provider who cannot practice with reasonable skill and safety by reporting to the Health Professional Services Program rather than to the licensing board. Reports submitted in good faith are immune from civil or criminal liability. Such reports should be based upon personal knowledge or observation that the professional is unable to practice with reasonable skill and safety because of an impairment rather than upon hearsay or a vague feeling that the professional might possibly have a problem.

The HPSP is available to licensed physicians, dentists, nurses, pharmacists, and podiatrists. For more information, call the HPSP at 612/643-2120. • • • • •

MMA Helps MADD Drive Home Dangers of Drunk Driving

Waseca high school students view the wreckage of a car that was struck by a drunk driver killing 16-year-old Tina Johnson.

The MMA sponsors a crashed car used by Mothers Against Drunk Driving (MADD) to show the devastating results of driving while intoxicated. The car was struck by a drunk driver in 1987 killing Tina Johnson, a 16-year-old Kilkenny girl. The wreckage drives home the message of MADD volunteers who travel throughout the state warning about the dangers of drunk driving. • • • • •

Announcements

Humphrey Named Chair of FDA Working Group

Attorney General Hubert Humphrey III has been chosen to chair the National Association of Attorneys General Working Group on the Food and Drug Administration. One of the issues Humphrey plans to pursue is the pharmaceutical companies' alleged practice of paying a commission to pharmacists who convince a patient to switch from one prescribed brand drug to their brand.

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You Can Block Caller-ID

In June, U S WEST introduced a new service called "Caller-ID," which allows subscribers to see the name or telephone number of any person within the U S WEST metro territory. Even callers who do not subscribe to Caller ID and those with unlisted or unpublished telephone numbers will have their identities displayed without their knowledge or consent to any subscriber with Caller-ID service.

U S WEST customers can protect their privacy by pressing *67 or dialing 1167 before dialing a number. This activates "Per Call Blocking," a feature installed on all metro-area phone lines. Dialing the three-digit code will block the caller's name and number from being displayed only on that call. Line blocking on all calls may be ordered free of charge from the telephone company. Call 800/637-9393 to order line blocking.

Conference Committee Could Help Medical Students

Minnesota Sens. David Durenberger and Paul Wellstone are conferees on a House/Senate conference committee that may decide the fate of medical student loan deferments.

The conference committee on the Elementary and Secondary Education Act has a chance to repair defects in the definition of "economic hardship" in the final regulations implementing the Higher Education Act. The final regulations, published in the July 1 *Federal Register,* would allow fewer medical students and residents to qualify for economic hardship deferment than the rules proposed by the Department of Education in March, which were supported by medicine. Unlike the proposed regulations, the final rules define "economic hardship" as a percentage of the federal poverty level and give no consideration to a borrower's debt-to-income ratio.

To remedy this situation, in August when the Senate passed legislation re-authorizing the Elementary and Secondary Education Act, it added two amendments that would reinstate the definition of "economic hardship" that had been included in the regulations proposed in March. This definition would allow borrowers to receive an economic hardship deferment if their monthly disposable income is no greater than four times the minimum wage or the poverty level of a family of two and their monthly student loan payments are at least 20 percent of their monthly disposable income. This definition would allow medical students who needed to postpone payment on their loans to be eligible for the three-year economic hardship deferment. The Senate language would also ensure that borrowers would be eligible for the same deferments regardless of the loan program in which their school participates. These amendments are not in the House version of the bill.

The MMA urged Durenberger and Wellstone to include the Senate language in the final bill, and it sent out an MMA Legislative Alert asking the support of the MMA Legislative Network.

MMA Medical Student Section Announces Officers

The MMA Medical Student Section has elected the following officers:

Chair: James Miner, Mayo Medical School
Vice-chair: Dina Andreotti, University of Minnesota, Twin Cities
Secretary: Janice Sinclair, University of Minnesota, Twin Cities
MMA delegate: Riico Dotson, Mayo Medical School
MMA alternate delegate: Mary K. Durfee, University of Minnesota-Duluth
Member-at-large: Bob McDonald, University of Minnesota-Duluth
Past-chair: Kim Koffler, University of Minnesota, Twin Cities

Michael Achinger was elected to the AMA Medical Student Governing Council at the June AMA Annual Meeting and he will serve as the student delegate to the AMA House of Delegates in June 1995. Timothy Olson is the new student representative to the MMA Board of Trustees.

LEGAL NEWS

Campaign Reform Law Is Under Siege

Minnesota's 1993 campaign finance reform legislation is embroiled in legal controversy.

The Eighth U.S. Circuit Court struck down a law meant to weaken the power of "independent expenditures," which fund campaign activities conducted without a candidate's knowledge or involvement and, therefore, fall outside the state's campaign spending limits. The law would allow the opponent of the candidate who benefited to go over the spending limits by the amount of the expenditure. It also would require advance warning be given to the opponent.

The challenge to this portion of Minnesota campaign reform law came from the Minnesota Citizens Concerned for Life and the Minnesota Education Association. These groups, which rely heavily on independent expenditures, argued that the law is an infringement of their constitutional right to free speech. Federal Court Judge Paul Magnuson let the law stand, but the Eighth Circuit Court of Appeals reversed his decision and ordered the state not to enforce the independent expenditures law.

Gov. Arne Carlson says he plans to appeal the court's decision all the way to the Supreme Court. "The court's ruling sets a very dangerous precedent by guaranteeing powerful interest groups the ability to attack candidates at will, while limiting the ability of those candidates to respond," Carlson said. "The court's decision gives a green light to special interest groups that want to control the outcome of campaigns. I am very disappointed that at a time in our history when the public is demanding campaign reform, the court has decided to reject the state's attempt to level the playing field."

In another blow to campaign reform law, the Circuit Court upheld the lower court ruling that the state cannot set a $100 limit on campaign contributions by political action committees (PACs). The state is not expected to appeal this portion of the decision.

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Border Docs Win Challenge to 2 Percent Tax

The eight physicians from Wisconsin, Iowa, and South Dakota who challenged the right of Minnesota to tax physicians who treat Minnesotans outside the state's borders won their lawsuit. The plaintiffs had sued the Department of Revenue on the grounds that Minnesota's tax on out-of-state physicians is unconstitutional.

Ruling in favor of the physicians, District Court Judge M. Michael Monahan on September 14 wrote, "The parties have not cited constitutional law that supports the notion that the reach of the state's taxing power follows its residents as they move from the state. ... As written, the Act's reach is nationwide. The hapless health care provider in California, Arizona, or Florida who unwittingly treats a bus-load of Minnesota tourists ... could find the commissioner at its door." The judge enjoined the state from enforcing all non-resident provisions of the 1992 Health Right Act, which created what is now called the MinnesotaCare program, including the 2 percent tax on out-of-state physicians.

Monahan had dismissed the case when it first came before him in November 1993 on the grounds that the court did not have jurisdiction because of a state anti-injunction law that prohibits lawsuits to restrain the assessment or collection of taxes. But in June 1994, the Minnesota Supreme Court reversed his decision and sent the case back to be decided on its merits.

The physicians were supported in their lawsuit by their state medical societies and the AMA.

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Court Supports Rights of Parents in End-of-Life Dispute

A battle over parents' rights to end medical treatment for their son came to an end September 9 when Ramsey Court referee James F. Finley decided in favor of the Butcher family. Their son, Jamie Butcher, had been in a persistent vegetative state for 16 years when his parents decided to take him out of the White Bear Lake Care Center and bring him home to die. The Ramsey County attorney's office blocked removal on the grounds that it would be "neglect" under the Minnesota Vulnerable Adult Abuse Act to withdraw artificial nutrition and hydration. The county attorney's office said the Butchers would have to be appointed their son's legal guardians and seek court approval before removing the feeding tube.

The MMA wrote to the Ramsey County court referee supporting the Butcher family's right to make decisions about their son's medical treatment. The MMA letter said that a family's decisions about medical care should not be challenged as long as they are based on true concern for the patient's welfare. The MMA called the Butcher family's decision "a deliberate and caring one made after years of contemplation and anguish about the right decision ... with input from health care and other appropriate professionals."

MMA comments followed consideration of the case by the MMA Committee on Ethics and Medical-Legal Affairs. Ramsey County attorney Tom Foley has decided not to appeal the case.

LEGAL NEWS

Physician "De-selection" Suit Dismissed in Texas

In a setback for physicians, a Texas federal judge dismissed a lawsuit challenging "de-selection" of Houston-area physicians by Aetna Health Plans. The plaintiffs in the case were five Houston physicians, the Harris County Medical Society, and the Texas Medical Association.

The lawsuit arose in response to Aetna's decision last September to drop 37 physicians from its Houston-area preferred provider organization (PPO), a network of more than 2,000 physicians. Sixteen of the 27 physicians appealed Aetna's decision and were reinstated. The plaintiffs plan to appeal the U.S. District Court's decision to the Fifth Circuit Court of Appeals.

The AMA is lobbying to add due process provisions for physicians into national health system reform legislation. The AMA's Patient Protection Act, introduced by Sen. Paul Wellstone and Rep. Collin Peterson, would protect physicians from being dropped from provider networks without explanation or power to appeal. Some of its provisions are included in various reform bills.

MINNESOTACARE NEWS

Benefits Set Is On the Fast Track

The rush is on to come up with a universal standard medical benefits set. The MinnesotaCare legislation requires that this benefits set be offered as an option by every health plan beginning in January 1996.

At its first meeting September 8, the Minnesota Department of Health's Universal Standard Benefits Set Advisory Committee swung into action, setting a demanding schedule of meetings. The committee plans to recommend a set of medical benefits to the commissioner of health by October 20.

A. Stuart Hanson, M.D., the MMA representative on the committee, gave committee members the MMA's 1991 basic medical benefits set as well as the MMA Guaranteed Benefits Task Force's recently completed report. The task force has updated the list of medical services recommended for the benefits package and will forward this list to the committee as soon as it is approved by the MMA Board of Trustees. As *The Monitor* goes to press, the proposed benefits package is on the agenda for the September 28 board meeting.

In addition to Hanson, the committee includes four other physicians: Charles Oberg, M.D., James Jordan, M.D., John McNamara, M.D., and Nancy Baker, M.D.

"Don't expect a minimum package from this group, but a comprehensive benefits set, including mental health services," predicted Janet Silversmith, MMA policy analyst. "While the committee is mindful of prices, they are not being driven by financial concerns."

The financial part of the picture will be sketched in by Deloitte & Touche, an actuarial firm hired by the Minnesota Department of Health (MDH) to price out the proposed benefit sets.

The Legislature asked the MDH to come up with five different cost-sharing plans. As of January 1, 1997, all health plans must offer only the universal benefits set within one of five approved cost-sharing options. These options may vary from a low premium option with high copayments to a high premium option with low copayments. Plans may also offer supplemental insurance options.

The Legislature mandated that dental services must be included in the medical benefits set. A separate committee is developing recommendations for the dental package.

The commissioner of health will use the committee's recommendations, the dental benefits committee recommendations, and the actuarial information from Deloitte and Touche to develop her report due to the Legislature in January 1995.

ISN Rule Making Is in Progress

The Minnesota Department of Health intends to propose two or three separate sets of rules governing integrated service networks (ISNs). The first set of rules is due in early 1995, the second in late 1995, and the third, if necessary, in 1996. The MDH will accept information and opinions from the public until a notice is published in the *State Register*.

The MMA will submit comments, based upon current MMA policy regarding ISNs. The MMA issued a report stating its position on ISNs in November 1993. For more information on ISN rule making or to comment, call Janet Silversmith at the MMA 612/378-1875 or 800/999-1875.

MINNESOTACARE NEWS

HTAC Evaluates Technologies

The Health Technology Advisory Committee (HTAC) expects to have preliminary reports on prostate-specific antigen (PSA) for prostate cancer screening and stereotactic radio-neuro surgery for brain tumors available for comment by mid-October. HTAC is charged by MinnesotaCare legislation with the task of evaluating high-cost drugs, devices, procedures, and processes, such as high-cost transplants and expensive scanners and imagers. HTAC published an evaluation of t-PA for treatment of acute myocardial infarction, which was reported in the July *Monitor*.

At its July meeting, HTAC selected four new technologies for evaluation:

- electronic fetal monitoring during labor;
- coronary artery bypass surgery (CABG) for stable angina pectoris;
- pancreas transplantation for patients with diabetes; and
- stereotactic radio-neuro surgery for brain tumors.

These four procedures join the list of those HTAC had previously selected for evaluation:

- high-dose chemotherapy with autologous stem cell rescue for breast cancer;
- magnetic resonance imaging (MRI) for diagnosis of headache;
- positron emission tomography (PET) for neurologic diagnosis; and
- prostate-specific antigen (PSA) for prostate cancer screening.

Del Ohrt, M.D., is the new HTAC chair, replacing David Lutes, who has resigned from HTAC. Susan Isernhagen is vice chair. In addition to the position vacated by Lutes, there will be additional vacancies in January 1995, when the the terms of five of the committee members expire.

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MDH Announces Committee Appointments

Timothy Crimmins, M.D., has been named to fill the MMA slot on the Risk Adjustment Association Interim Board of Directors. The Risk Adjustment Association will submit a report to the Legislature recommending ways to even the playing field for health plans whose enrollees are older and sicker by transferring money to them from those health plans whose enrollees are younger and healthier. The Risk Adjustment Association must submit its report to the Legislature by January 15, 1995, and the risk adjustment system should be in place by July 1, 1997.

The MMA representative on the Medical Education and Research Costs (MERC) Advisory Task Force is Byron Crouse, M.D., of the University of Minnesota-Duluth. The MERC Task Force will study the impact of health reform on the financing of medical education and research and recommend ways to fund medical education and research. The task force must submit its report to the Legislature by February 15, 1995.

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Health Plan Action Plans Are Available

The 1994 MinnesotaCare legislation required health plans to file action plans. Copies of these plans are now available to the public. To obtain a copy of an action plan, call the Minnesota Health Information Clearinghouse at 612/282-6314, or write to the office at 121 East Seventh Place, PO Box 64975, St. Paul, MN 55164-0975. The action plans will include information on provider credentialing requirements; the number of providers used to provide services, including use of mid-level practitioners and allied professionals; the policy for determining the number and type of providers necessary to deliver care to enrollees; internal use of report cards, outcome studies, and complaint information; policies to serve high-risk and special needs populations; and plans to offer coverage to rural communities and other communities not currently served.

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Data Institute Seeks Consultant

The Minnesota Health Data Institute seeks a consultant to help its Ethics and Confidentiality Committee develop and implement policies, including legislative strategies and proposals relating to personal privacy protection and the appropriate access to and disclosure of health care data collected to support health system reform in Minnesota. The consultant will work with a committee of interest group leaders and technical experts to complete the following tasks by December 1, 1994: 1) review and analyze existing privacy/confidentiality policies, practices, guiding principles, and applicable laws, and 2) develop recommendations for policies and legislative actions needed to achieve the goals of the committee. The consultant must also be available through early 1995 to help present committee proposals to the legislature and other groups. The consultant should have the experience and skills to help carry out objective, nonpartisan policy analysis; knowledge of health care data privacy, confidentiality, access, and disclosure issues; technical knowledge of health information systems and electronic data interchange; knowledge of the legislative process; and the ability to work with diverse groups. To obtain a request for proposals, contact Maria Haack, Minnesota Health Data Institute, Piper Jaffray Plaza, Suite 910, 444 Cedar Street, St. Paul, MN 55101; 612/228-4373 or 612/222-4209. Proposals are due by 4:30 p.m. on October 6.

RURAL NEWS

New Project Increases Number of Rural Nurses

During the first year of the Collaborative Rural Nurse Practitioner Project, 33 percent of the nurse practitioner students admitted to graduate programs came from rural Minnesota communities and plan to return home to practice—a success rate well above the project's goal of 25 percent. Five of these students live in Health Professional Shortage Areas.

In this project, all of the Minnesota graduate nurse practitioner programs are working together to increase the supply of nurse practitioners in rural Minnesota. Faculty coordinators from each of the schools are working with health care providers in or near the students' communities to develop clinical practice sites where the students can learn the clinical skills needed to practice as nurse practitioners.

In collaboration with the Office of Rural Health and Primary Care and the Minnesota Center for Rural Health, the project will target rural communities that need primary health care services. The project will try to identify potential students and help communities support them through their training so eventually they will set up a primary care practice in the community.

This collaborative project responds to the Minnesota Legislature's 1993 grant initiative and is funded by the Minnesota Higher Education Coordinating Board.

Grant Awarded to Recruit Primary Health Care Providers

The Robert Wood Johnson Foundation has awarded the Minnesota Department of Health $777,245 to recruit primary health care providers for medically underserved rural and urban areas. The Minnesota Department of Health's Office of Rural Health and Primary Care will be the lead organization for the project and will work with the Minnesota Center for Rural Health, a private, nonprofit organization. The project's goal is to place 35 physicians and mid-level practitioners in underserved areas in 1994-95, 38 in 1995-1996, and 42 in 1996-1997. The state of Minnesota and private organizations will also contribute funding to this project.

MEDICARE NEWS

Proposed HCFA Rule Would Revise GPCIs

The Health Care Financing Administration (HCFA) has proposed a Medicare rule that would revise the geographic practice cost indices (GPCIs), which estimate the cost of running a physician's practice in various parts of the country, and adjust Medicare rates accordingly. The AMA predicts the changes under the new GPCIs would be small and would be phased in over two years. For Minnesota, the change would mean a reduction of 1.4 percent in the GPCI. This loss may be offset by an increase in the conversion factor, but that remains uncertain.

The proposed rule, published in the June 24 *Federal Register*, also includes interim work relative-value unit (RVU) recommendations for some carrier-priced and non-covered Medicare services to allow adoption of the Medicare fee schedule by other payers, and it proposes to convert Iowa to one statewide payment area.

For further information, contact Janet Silversmith at the MMA, 612/378-1875 or 800/999-1875.

Fraud and Abuse Safe Harbors Clarified

The Office of Inspector General of the Department of Health and Human Services (OIG) has issued proposed regulations clarifying some of the Medicare fraud and abuse safe harbor regulations that were published in July 1991. The OIG is not trying to re-evaluate the original safe harbors, but rather, to remove ambiguities in the original language in order to protect the business practices that were intended to be protected from the Medicare anti-kickback provisions. The regulations clarify the safe harbors for investment interests, space or equipment rental and personal services, management contracts, referral services, and discounts. The proposed regulations are published in the July 21, 1994, *Federal Register*.

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Community Integrated Service Networks

CISNs are intended to level the playing field between urban and rural Minnesota in establishing health care delivery through integrated service networks.

Andrew H. Seitel, J.D., and Aaron M. Rodriguez, J.D.

The MinnesotaCare Act of 1993 introduced the concept of integrated service networks as a means to increase health care access and reduce costs throughout the state. However, early on, health care professionals questioned whether implementing the ISN concept in rural areas would be feasible. It became apparent that an alternative to ISNs was essential to guarantee that rural communities were given a level playing field with their urban counterparts. Thus, the idea for community integrated service networks (CISNs) was born and recommended to the 1994 Legislature.

Legislative Background

To understand the concept of CISNs, it is essential to first understand integrated service networks as envisioned by the 1993 Legislature. The Legislature anticipated that ISNs would be well-established by July 1997 under MinnesotaCare.

An ISN is a network of hospitals, physicians, and other health care professionals that provides health services to the ISN's members, or enrollees, for a capitated fee. ISNs will be responsible for providing a broad spectrum of high-quality health care services to their enrollees while containing the cost of that care. A recent study on the development of ISNs in Minnesota observed that ISNs are "based upon the concepts pioneered by the most innovative HMOs and, in many ways, represent the next generation of this approach to health care delivery."[1] Although ISNs are similar to HMOs, they are intended to be more flexible in terms of their relationships with health care providers and more sophisticated in their management of patient care. Recently, several potential ISNs have evolved, including the merger of HealthSpan and Medica to form Allina, the HealthPartners/St. Paul-Ramsey Medical Center merger, and the alliance between Blue Cross and Blue Shield of Minnesota, Fairview Health System, and the University of Minnesota.

ISNs are designed to take advantage of economies of scale and efficiency of delivery of health care services. From the start, many health care professionals recognized that the ISN concept may be difficult to implement in rural areas. A report prepared for the MinnesotaCare Legislative Oversight Committee by the University of Minnesota's Institute for Health Services Research and Policy recognized that ISNs would be challenged by assuming the risk inherent in a capitated health insurance plan while delivering the services promised under their contracts. Small, community-based ISNs will be especially vulnerable to the financial risk they must bear. Consequently, the report found, provisions must be made to allow a variety of competing ISNs to enter the marketplace while assuring the public that each is fiscally sound.

At the same time the Institute for Health Services report was released, Minnesota's commissioner of health released the "Implementation Plan and Recommendations for Integrated Service Networks and a Regulated All-Payer Option (RAPO). In 1993, MinnesotaCare legislation required that the commissioner of health, in consultation with the Minnesota Health Care Commission, develop a detailed implementation plan and propose legislation to implement health care cost containment in Minnesota. These recommendations were based on several public meetings and hearings conducted by the Department of Health and the commission, along with recommendations of various advisory groups.

As a result of meetings and discussions conducted by the commission and the Department of Health, it became clear that rural communities were concerned about implementation of the ISN concept in greater Minnesota. Historically, HMOs have not been significant players in the rural health care delivery system. The working groups became concerned that urban health plans could envelop and harm local rural health care delivery systems. Thus, the working groups developed legislation to facilitate the development of rural ISNs, which came to be called community integrated service networks, and the commissioner recommended this legislation to the 1994 Legislature.

The Birth of CISNs

In creating CISNs, the Legislature sought to promote the development

of small, community-oriented networks. It gave these networks a head start by allowing them to form earlier than ISNs and by providing a framework designed to allow a smoother transition into the ISN/RAPO-based regulatory environment.

MinnesotaCare requires that by July 1, 1997, all health care in the state be delivered through ISNs, CISNs, or under RAPO. Since CISNs were allowed to apply for licensure as of July 1, 1994, to begin operation on January 1, 1995, there has already been significant interest in CISN development.

As discussed below, the regulatory requirements for a CISN, in general, mirror that of an HMO—but there are some notable exceptions.

CISN/HMO Regulation

The 1994 MinnesotaCare amendments creating CISNs borrow heavily from the HMO regulatory framework. Like HMOs, CISNs represent a formal arrangement, licensed by the commissioner of health under Minnesota statutes, to provide a broad spectrum of prepaid health services to enrolled populations. The following paragraphs describe regulation common to CISNs and HMOs.

Minnesota's Health Maintenance Act of 1973 sets out the basic application and regulatory requirements for HMOs, which, with some exceptions, CISNs must also meet. The HMO Act defines an HMO as a nonprofit organization that "provides ... comprehensive health maintenance services ... to enrollees on the basis of a fixed prepaid sum without regard to the frequency or extent of services furnished to any particular enrollee." Comprehensive health maintenance services are defined as "a set of comprehensive health services which the enrollees might reasonably require to be maintained in good health including as a minimum, but not limited to, emergency care, emergency ground ambulance transportation services, in-patient hospital and physician care, out-patient health services, and preventative health services." The benefit set—the set of health services that HMOs must deliver—is defined more specifically in the Minnesota Rules.

When applying for a license to operate as an HMO, the applicant organization must provide a general description of the HMO structure, its directors and officers, its financial situation, its provider agreements, its enrollee information packets, and a description of its marketing efforts. An organization seeking to gain CISN licensure must provide similar information with its application. Once the commissioner grants a certificate of authority, he or she continues to monitor many aspects of the HMO or CISN, including reserves, net worth, governance, coverage for enrollees, annual reporting, and quality assurance. These areas of regulation are described briefly below.

Because CISNs will play a vital role in both the delivery of health care and the containment of the state's overall health care expenditures, the commissioner will closely monitor their financial stability, as is currently the case with HMOs. For example, HMOs must secure substantial deposits, net worth, and working capital as protection against insolvency. Moreover, HMOs are regulated with respect to what investments are allowable.

CISNs, like HMOs, must meet detailed reporting requirements so that the commissioner and enrollees stay informed about the CISN's operations. CISNs must provide, for example, evidence of coverage to their enrollees and to the commissioner. CISNs must also file annual reports with the commissioner reflecting any significant changes in operations as described in their applications.

Minnesota statutes also regulate who HMOs and CISNs must cover and what services they must provide to their members. For example, continuation and conversion privileges for former spouses and children of enrollees, out-of-area conversion requirements (which regulate how to handle enrollees who live outside the service area), coverage for current spouses and children, and dependent coverage are all regulated by Minnesota statutes. Contracts between CISNs and their associated health care providers are also regulated, as are CISN and HMO contracts. For example, when contracting with health care providers, CISNs must include a contractual provision against balance billing.

Like HMOs, CISNs are prohibited from engaging in certain activities, such as false advertising. Moreover, they must observe restrictions on cancellation of an enrollee's coverage or failure to renew an enrollee's coverage, particularly with respect to retaliatory actions. When a CISN's enrollee raises complaints against the CISN, the CISN must comply with a statutory dispute resolution mechanism. Finally, CISNs must avoid expenses that are "unreasonably high in relation to the value of the service or goods provided." With HMOs, the definition of "unreasonably high" has consistently been the subject of much debate.

Ultimately, violation of applicable rules and regulations comes at a price. As with HMOs, the commissioner of health may suspend or revoke any certificate of authority issued to a CISN.

CISN Regulations

Unless specifically excepted from HMO regulations, CISNs are subject to all the same requirements as HMOs. There are, however, some substantial differences between the two models, and some of these differences reflect the concerns raised about rural health care prior to the 1993-94 legislative session. Following is a summary of the CISN regulations that differ from HMO regulations.

Size: In order to facilitate the growth of CISNs in greater Minnesota (although they are not limited to rural areas), and to allow CISNs a competitive head start, CISNs are limited in size. Unlike HMOs, CISNs will be limited to 50,000 or fewer enrollees, with some exceptions. This arrangement encourages the formation of CISNs in greater Minnesota, where small populations make larger organizations impractical and the need for alternative means of health care delivery is most prevalent.

Governing body: The 1994 amendments require that a majority (at least 51 percent) of the governing board of a CISN be residents of the CISN's service area—presumably in

hopes of encouraging the CISN to be responsive to the needs of the community it serves.

Benefit set: CISNs, like HMOs, must provide a benefit set as required by statute. But unlike HMOs, CISNs may impose a deductible (excluding preventive services) of up to $1,000 per person per year, provided that out-of-pocket expenses do not exceed $3,000 per person or $5,000 per family per year. This requirement allows CISNs to share a fixed amount of risk with their enrollees.

Solvency and net worth regulation: As with HMOs, the commissioner will closely scrutinize the financial stability of CISNs. However, CISNs have separate deposit, reserve, and solvency requirements from HMOs—the 1994 amendments impose new requirements for CISNs. Until June 1, 1995, the commissioner may engage in rule-making on those issues without being subject to standard rule-making notice and comment requirements. In theory, this means rules may be adopted and implemented with little or no warning to CISNs.

As with HMOs, CISNs are subject to fairly strict net worth requirements—that is, CISNs must maintain a positive balance of assets over liabilities. CISNs have both a floor and a ceiling net worth requirement. At a minimum, CISNs must maintain a minimum net worth of the greater of a) $1 million; b) 2 percent of the first $150 million in annual premium revenue plus 1 percent of annual premium revenue in excess of $150 million; c) 8 percent of the annual health services costs (except that for risk-sharing arrangements, only 4 percent of the annual costs are considered); or d) four months of uncovered health services costs. At the high end, net worth shall not be more than 2.5 times the required minimum.

In order to ease the burden on start-up CISNs, the requirements may, at the option of the CISN, be phased in over time. If that option is chosen, 50 percent of the requirements must be met when the CISN begins enrolling members, 75 percent must be met by the end of the first year, 87.5 percent by the end of the second year, and 100 percent by the end of the third year.

The law also allows CISNs to reduce their net worth requirements by the amount of risk ceded to accredited capitated providers, defined as health care professionals who agree to provide services to CISN enrollees for 120 days without pay should the CISN become insolvent. These ACPs must furnish financial data to the commissioner annually to prove financial stability. In no event, however, may the CISN net worth requirement fall below $1 million. This reduction does not affect the phase-in of the net worth requirement.

Coverage for enrollees of insolvent CISNs: In addition to the ACP arrangement, the Legislature sought to protect enrollees of insolvent CISNs by assuring that they receive coverage from another source should their parent CISN become insolvent. The 1994 MinnesotaCare amendments require that other CISNs accept enrollees from insolvent CISNs in certain circumstances. This requirement emphasizes the overall goal of universal coverage, to which CISNs must contribute by remaining flexible and able to care for the enrollees of insolvent CISNs.

Allied provider requirement exemption: One of the most controversial debates surrounding CISNs involved allied providers. Under MinnesotaCare, ISNs cannot deny network affiliation to chiropractors, physical therapists, optometrists, podiatrists, psychologists, and other allied providers unless they do not comply with the carrier's policies and managed care protocols.* However, some groups involved in the legislative process were concerned that CISNs would not be able to maintain financial viability and effectively compete in a managed care environment if this allied provider requirement applied to them. Thus, under the 1994 MinnesotaCare amendments, all health plan companies with more than 50,000 enrollees that are not staff-model HMOs must establish an expanded network of allied providers in addition to any preferred network. CISNs, which must have fewer than 50,000 enrollees, are excluded from the requirement, but they may offer such an expanded network if they so choose. This exception from the allied provider requirement allows CISNs to exercise greater control over their member providers.

Miscellaneous regulation: Several exceptions to HMO requirements are more technical than substantive in their effect. For example, CISNs are exempt from some of the reporting requirements placed on HMOs. CISNs are also exempt from other miscellaneous HMO requirements, such as conducting focused studies, preparing and filing quality assurance and marketing plans, maintaining specific statistics, filing form provider contracts, and reporting any changes in the provider network to the commissioner of health.

Conclusion

The recently completed third year of MinnesotaCare reform legislation continues to reshape the delivery of health care in the state. By 1997, all heath care delivery will occur through ISNs, CISNs, or RAPO. As of January 1, 1995, CISNs may start providing health care services to their Minnesota enrollees. The beginning of CISN operation reflects one aspect of the shape of things to come as integrated delivery systems take on increasingly large roles in Minnesota and elsewhere. As managed care networks continue to consolidate, policymakers hope that CISNs will provide small communities the same opportunities as their urban counterparts. MM

Andrew Seitel and Aaron Rodriguez are attorneys at the law firm Popham Haik Schnobrich & Kaufman, Ltd., in Minneapolis.

**Allied providers must do the following to be included in the extended network: 1) meet the health plan company's credentialing standards; 2) agree to the terms of the health plan company's provider contract; and 3) agree to comply with all managed care protocols of the health plan company.*

REFERENCE

1. The Department of Integrated Service Networks in Minnesota. Minneapolis: Institute for Health Services Research, University of Minnesota School of Public Health, 21 February 1994.

Minnesota Health Care Provider Cooperatives

Cooperatives offer a flexible option for health care providers who want to act collectively without merging their assets.

James S. Matthews, J.D.

The 1994 state Legislature created a new, more flexible option for health care providers to act collectively to contain health care costs, improve the quality of health care, and increase access of Minnesota citizens to health care services. The Minnesota Health Care Cooperative Act, part of the larger MinnesotaCare bill, creates a vehicle for separate health care provider groups to work together without merging their assets.

The act permits health care providers, such as hospitals, physicians, and other health care practitioners, to organize health care provider cooperatives, and it permits health care purchasers to organize health care network cooperatives. By organizing cooperatively and acting collectively, health care providers and health care purchasers can realize economic efficiencies they cannot achieve separately. These efficiencies should reduce overall health care costs and increase local participation without sacrificing health care quality.

What Are Provider Cooperatives?

Health care provider cooperatives are intended to provide a more flexible vehicle for collaboration among health care providers than is offered by other forms of organization currently available, such as clinics without walls, physician hospital organizations, and joint ventures. These various organizations may take the form of partnerships, professional corporations, business corporations, limited liability companies, limited liability partnerships, not-for-profit corporations, and even business trusts. Each of these options has advantages and drawbacks. No one model is best for all circumstances. Health care provider cooperatives are not meant to be the ideal model for provider collaboration in every situation, either, although they may be more flexible than other models in certain circumstances.

The basics

In general, health care provider cooperatives are joint ventures among licensed health care providers to collectively sell their services on a risk-sharing basis to purchasers of group health benefits, such as integrated service networks (ISNs), health maintenance organizations (HMOs), or commercial insurance companies. Providers do not need to merge their assets in order to be members of a health care provider cooperative. In addition to physicians and hospitals, membership may also include professional corporations and partnerships and may possibly include cooperatives composed of licensed health care providers, although the Minnesota Health Care Cooperative Act is ambiguous in this latter regard. (In non-health care situations, cooperatives are frequently members of other similar cooperatives.) Health care provider cooperatives will market health care services to health care network cooperatives, HMOs, ISNs, community integrated service networks (CISNs), government plans, and, potentially, ERISA-exempt employers. The services will be delivered primarily, but not necessarily exclusively, by the cooperative's members, who will be contractually obligated to deliver some of their services through the cooperative.

Health care provider cooperatives must sell their member services on a "substantially capitated or similar risk-sharing basis." This statutory pricing requirement is intended to encourage providers to be efficient, both individually and collectively. This risk-sharing also results in a degree of forced integration that helps minimize antitrust concerns, as discussed later in this article.

Legal organization and financing

Health care provider cooperatives are likely to be incorporated, thus limiting the liability of the cooperative's members for the debts and obligations of the cooperative and giving the cooperative perpetual life. Provider cooperatives will be financed by member contributions or by common stock purchases, the sale of nonvoting preferred stock, or by the retention of patronage refunds. Dividends on stock, however, cannot exceed 8 percent annually.

As agents of their members, health care provider cooperatives will serve their members at cost. However, if a

cooperative realizes income in excess of expenses, it will distribute these earnings to its members (and possibly to nonmember patrons) as patronage refunds, sometimes called patronage dividends. These refunds or dividends will be in addition to the basic payment realized by providers for delivering their services through the cooperative.

Taxation

If a health care provider cooperative elects to be taxed as a cooperative and satisfies certain federal income tax requirements, its patronage-based earnings will not be taxable to the cooperative. Instead, the earnings will be taxable to the cooperative's members when paid to them as patronage refunds. Otherwise, cooperative corporations are subject to double taxation, like most general business corporations.

To take advantage of favorable tax treatment, most health care provider cooperatives will ultimately be controlled by their members on a one-member/one-vote basis. Members generally vote to elect a board of directors and vote on other particularly major corporate actions, such as mergers. The act, however, provides great flexibility in governance, allowing for other voting procedures and requirements, although making such modifications may create tax planning concerns. In practice, meeting the one-member/one-vote rule may not be of significant practical concern, since there are a variety of legitimate ways to meet the requirement while still creating an appropriate balance in governance.

Legal clarifications

The development of provider cooperatives was meant to provide greater flexibility under a variety of state laws, which up to this point have made provider joint ventures somewhat cumbersome. With respect to health care provider cooperatives, the act clarifies that 1) the corporate practice of medicine doctrine is inapplicable (in other words, it is ethical for a cooperative to directly employ a physician, if desired); 2) the cooperative and its members are not deemed to be engaged in the business of insurance or to be acting as a health plan merely because it accepts capitated or risk-sharing contracts; 3) a cooperative has the potential ability to deal directly with self-insured employers on a capitated basis, although there currently is significant regulatory debate on this point; and 4) referrals within the cooperative do not violate state limitations on provider self-referrals, although care must be taken to assure compliance with applicable federal standards concerning Medicare and Medicaid and the so-called "Stark-II" law.

Moreover, the shares of stock in the cooperative issued to members do not have to be registered under state, and in some cases, federal, securities law, subject to some limitations. This is similar to shares in a physician professional corporation. This exemption from registration may help reduce the expense of starting a cooperative compared with some other forms of joint ventures.

Antitrust Issues Minimized

In addition to the simplifications described above, the Legislature also sought to provide additional antitrust comfort to providers seeking to form cooperatives. While both state and federal antitrust laws in general apply to the activities of health care provider cooperatives, the Minnesota Legislature took four steps to minimize antitrust concerns.

Recognition and protection

The Legislature provided direct recognition of health care cooperatives and provided explicit protection under state antitrust laws for certain activities inherent to the formation and basic operation of the venture.

Forced integration

Because a state government cannot interfere directly with federal antitrust law, the Legislature also imposed upon provider cooperatives a certain degree of forced integration through risk-sharing contracts. This integration was intended to create incentives to reduce health care costs and increase quality, and also to help create operational efficiencies. These efficiencies tend to bolster the characterization of provider cooperatives as legitimate joint ventures under federal antitrust law.

Prohibited practices

The Legislature limited the ability of health care cooperatives to take inappropriate action based on high market concentrations by prohibiting certain practices and by creating a layer of regulatory oversight. The act requires cooperatives to file provider contracts with the Department of Health, which may disapprove contracts between a cooperative and a third-party payer that call for payments that are unreasonably high in relation to the value of services or goods provided. The Department of Health exercises the same authority over contracts between HMOs and health care providers. This filing requirement provides an opportunity for an independent state agency to review and potentially limit above-market priced contracts and impedes marketplace abuses by provider cooperatives.

Market abuse also might arise if the provider cooperative has a significant portion of providers in a given geographic market as members. In some circumstances, the cooperative might be tempted to corner the market by requiring that individual members contract with health plans exclusively through the cooperative. Such provisions could limit the development of competing cooperatives or limit the ability of health plans to establish their own provider networks. Because the potential for abuse is so great, the Legislature has expressly forbidden provider cooperatives from requiring that their members deliver health care services exclusively to or through the cooperative.

A third potential abuse also is related to concerns about exclusivity. Once a provider cooperative has been established in a given geographic market, there could be a tendency for the cooperative to contract with one favored health plan and attempt to freeze out other health plans. To foreclose those and similar marketplace abuses, the Legislature made it unlawful for health provider cooperatives to engage in any acts of "coer-

cion or intimidation or boycott of, or any concerted refusal to deal with" any health plan company, such as an HMO or ISN, seeking to contract with the cooperative on a "competitive reasonable and non-exclusive basis."

Concerned that individual providers might be subject to pressure from existing health plans or other providers not to participate in a cooperative, the Legislature prohibited any persons from engaging in acts of coercion, intimidation, or boycott, or from refusing to deal with any health care provider based on that provider's actual or potential participation in a health care network or health care provider cooperative. This prohibition explicitly forbids requiring a person to agree not to join or become a member of a health care provider cooperative as a condition of securing or retaining a contract for health care services.

Antitrust exemption

The cumulative effect of the explicit recognition, the forced integration, and the prohibited practices may be to increase the likelihood that the cooperative is in compliance with the antitrust law and that state health regulators will approve applications by provider cooperatives for exemptions under the state action antitrust exemption statute if such an exemption is sought.

Conclusion

Health care provider cooperatives may create some flexibility for providers by modifying certain state laws that in the past have discouraged or made joint ventures more difficult. However, this flexibility is not a magic wand; the act does not "fix" all the laws that may inhibit joint activity. Federal tax laws, laws concerning pension and profit-sharing plans, laws generally applicable to providers, and insurance laws remain issues of concern. Moreover, because the act requires health care provider cooperatives to contract on a "substantially capitated or risk-sharing basis," the cooperative model would obviously be irrelevant or less desirable for providers unwilling or unable to accept the risk or if local market conditions do not favor the development of capitated or risk-sharing contracts.

In summary, health care provider cooperatives are merely one more arrow in the organizational model quiver, and health care providers should carefully analyze whether the business goals and capabilities of the ventures are best achieved through a cooperative or another form of organization. MM

James Matthews is an attorney with the law firm Lindquist & Vennum in Minneapolis.

A 55-page "Basic Guide to Minnesota Health Care Provider Cooperatives" is available for $75 from the Minnesota Hospital Association for those interested in greater detail about this form of organization. Call Rich Korman at the MHA, 612/331-5571.

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Medicine's Identity Crisis Revealed

The Asclepius vs. the Caduceus

BY PAUL T. FRETT

It's used in connection with health care news on "The MacNeil-Lehrer NewsHour," "NBC Nightly News," and CNN. Both the Minneapolis-based *Star Tribune* and the *St. Paul Pioneer Press* use it to introduce periodic health care columns.

Within the health care industry, it's the official symbol of the Army Medical Corps, it appears in the logo of the Association of American Medical Colleges, and it represents a variety of public health organizations. It can be seen on everything from business cards to clinic logos and, in Minnesota, it is even cast in bronze on the elevator doors of the Medical Arts Building in Minneapolis.

It's the caduceus—a winged staff intertwined by two snakes. It has long been associated with the health care field, but is it the symbol of an industry concerned with healing? Unless health care enjoys being connected with rogues, thieves, and even souls of the dead, the caduceus is *not* the proper medical symbol.

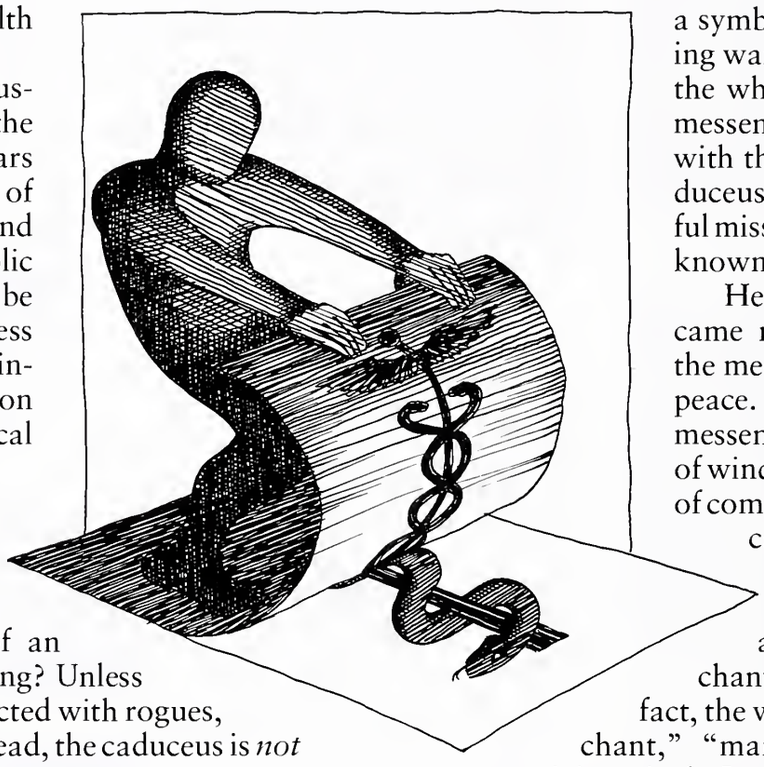

ILLUSTRATION BY MICHAEL MAY

Uncovering a False Symbol: The History of the Caduceus

The medical field is in the middle of an identity crisis so old and so entrenched that many people associated with the profession don't even know it exists. Although often associated with medicine, when the layers of practice logos, corporate identities, and news story introductions are stripped away, the true implications of the caduceus leave much to be desired as a symbol of the profession.

The present-day caduceus finds its origin in the Greek god Hermes (or Mercury in Roman mythology). As a sign of his position as messenger for the gods, Hermes secured a knotted olive branch as his heralder's wand. Legend tells that two intertwined snakes were added when Hermes separated them from fighting. In appreciation of his kindness, the two snakes wrapped themselves around the olive branch. Wings were later added as a symbol of Hermes speed, and the caduceus was born.

Hermes' wand soon became a symbol of the messenger. During war time it was used much as the white flag is today. When a messenger was sent to negotiate with the enemy, he carried a caduceus as a symbol of his peaceful mission. He was, furthermore, known as a caduceator.

Hermes and the Caduceus came no closer to representing the medical profession in time of peace. In addition to his role as messenger, Hermes was the god of wind and air, as well as the god of commerce and merchants. The caduceus became a symbol of trade and prosperity and, thus, was adopted by many merchants and entrepreneurs. In fact, the words "commerce," "merchant," "market," and "mercantile" originate in the Latin words "mercis" (goods) and "mercor" (to traffic), which relate to Hermes' parallel identity as the Roman god Mercury.

Upon further study of Hermes' other exploits, his reputation and the subsequent inferences of his symbol take a turn for the worse. Hermes was also god of rogues, thieves, and traitors. As if these extra duties were not enough, Hermes was also assigned the task of transporting the souls of the recently dead to hell—not the type of activity desired in a symbol of health and healing. He was very taken with the baser passions. And the closest contact he had with medicine came during his regular "consorts" with the goddess of health, Hygeia.

In a 1983 article in *Alabama Medicine*, Robert H. Elsner, director of the Los Angeles County Medical Association, stated, "the caduceus was simply the herald's wand of the winged god Hermes, and was—and still

should be—an emblem of all his numerous duties, *which did not include medicine.*"

Would the Real Symbol of Medicine Please Stand Up?!

The dethroning of such a widely known symbol as the caduceus would seem to leave quite a hole in the identity of the medical profession. On the contrary, a uniquely medical symbol untainted by the less than desirable exploits of a promiscuous god has existed since before the second century B.C.

Mythology defines the Greek god Asclepius and his Roman counterpart, Aesculapius, as the god of medicine. A myth started by the Greeks and expanded by the Romans places Asclepius as the son of Apollo, the sun god, and a mortal woman. He was brought up by the centaur, Chiron, who taught him the art of healing. He was bestowed the title of god of medicine when his skills surpassed those of his teacher; in fact, his patients never died.

The healing practices of Asclepius were passed down from father to son, each generation being referred to as Asklepiads or healing priests. They practiced their skills in magnificent temples, considered the origin of modern hospitals.

Since the second century B.C., their symbol, the staff of Asclepius, a rough knotty staff with a single snake coiled around it, has served as the true symbol of medicine. Unlike the caduceus, its meaning seems to have developed from a utilitarian standpoint rather than as a sign of position or authority. The sturdy nature of the staff made it a very good crutch for the crippled visiting the temples. Likewise, the snake itself has both a practical and metaphorical meaning. The snake has long been a symbol of regeneration due to the annual renewal of its skin and, thus, its association with a symbol of healing is understandable. In addition, the particular species of snake found on the staff of Asclepius, the *Elaphe longissima*, was an integral part of the temples. Because of its natural diet of rats, the Asklepiads used it as biological pest control. As it became a more prominent fixture, it began to play an important part in the rituals of the temples.

Part of the beginnings of modern medicine, the staff of Asclepius embodies the true meaning of the medical profession and deserves to be recognized accordingly.

One Snake, Two Snakes—Why the Confusion?

How did these two symbols, one blatantly medical and the other blatantly not medical, become confused in the first place? The caduceus and the staff of Asclepius have been tangled in a history of mistaken identity that reaches back before the Romans, before the Greeks—back to the very beginning of civilization.

According to Glenn W. Geelhoed, M.D., the two kingdoms of Egypt, upper and lower Egypt, united under the pharaoh Menes, circa 3400 B.C. As a part of the unification, the priesthoods of the two kingdoms merged, with the symbols of the two cults appearing together for the first time. In the lower kingdom, where serpent worship prevailed, the snake was revered as the symbol of the living circle and eternity. The upper kingdom worshipped the hawk god. At the time of unification, a double snake symbol surmounted by the wings of a hawk was created to represent the new kingdom. Later this double snake symbol was merged with yet another Egyptian state symbol, a thick, knotted staff with a single serpent. From this point, the confusion begins!

It wasn't until relatively recent times that the paths of the two symbols crossed within the field of medicine. Called a usurper, "a latecomer to medical symbolism and pretender of suspect legitimacy," by Geelhoed in a 1988 article in the *Southern Medical Journal*, the caduceus is considered a newcomer to the health care profession. According to Geelhoed, the caduceus has made various cameo appearances in medicine over the last 300 years. During the 16th century in Switzerland, printer Johann Froben placed his crest, which contained a caduceus, on the first page of everything he printed. Although he was a general printer, he did print medical books, which may have introduced this commercial symbol to the medical profession. Around the same time period, the caduceus also appeared in the coat of arms given to Sir William Butts, physician to King Henry VIII, at his knighting.

In America, Josiah Flagg Jr., one of the earliest American dentists, used the caduceus in his advertising in 1792. And in 1844, English publisher John Churchill used the caduceus on the title page of medical books that he published. "We see the caduceus creeping into the English language from the commercial messenger to an emblem of medicine by association," states Geelhoed.

The caduceus as "emblem of medicine by association" came to fruition in 1902 when the U.S. Army Medical Corps adopted the caduceus as its official symbol. Although it was an appropriate sign of the medical corps' noncombatant status similar to caduceators, this move legitimized the case of mistaken identity, diverting attention from the staff of Asclepius (the true medical symbol) and affirming the caduceus' erroneous association with medicine until the modern day.

continued

A Matter of Image

Once and for all, the caduceus is not the proper symbol of medicine. This issue may seem like merely an entertaining anecdote about mistaken identity; however, as health system reform continues, the ideas of marketing, provider relations, and other image-based activities will take on an increasingly prominent role in the practice of medicine.

The medical profession should follow the example of the American Medical Association, the Minnesota Medical Association, and the Los Angeles County Medical Association. Not wishing to be connected with the likes of Hermes and his less-than-desirable exploits, these and other health organizations have spurned the caduceus in favor of the true sign of health care—the staff of Asclepius.

Within the setting of increased competition, an image that harkens back to the foundation of modern medicine, an image that conveys commitment to the healing arts—the image of the staff of Asclepius—will be the preferred identity for the medical profession. MM

Paul Frett is an account executive at G.R. Barron and Company, a St. Paul-based public relations and marketing communications firm specializing in medical and health care marketing.

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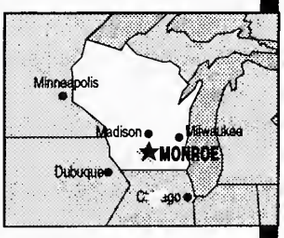

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
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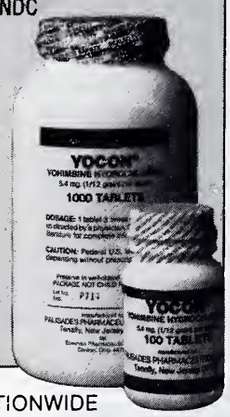

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People and Places Making Medical News

People

UMD Students Receive Awards

The University of Minnesota-Duluth School of Medicine awarded medical student **Peter Wodrich** with its recently established William Jacott Family Medicine Award and medical student **Robert McDonald** with its Reino Puumala Award this summer.

The new William Jacott Award, which will be presented annually by the Department of Family Medicine to an individual who reflects the values and interests of family medicine, was established in recognition of **William E. Jacott, M.D.**, and his efforts to establish the School of Medicine and the Duluth Family Practice Residency. Jacott, currently assistant vice president for health sciences and associate professor with the Department of Family Practice, University of Minnesota, Minneapolis, was formerly a family physician in Duluth and the first director of the Duluth Family Practice Residency. He also is a Trustee with the American Medical Association. The Reino Puumala Award, re-instituted this year after last being awarded in the late 1980s, is in honor of the late Reino Puumala, M.D., a family physician from Cloquet who also was instrumental in establishing the School of Medicine in Duluth.

Red Cross Management Appointments

St. Paul Blood Services Region of the American Red Cross recently announced four new senior management appointments: **Joyce Williams**, senior manager and chief operating officer; **Ted Eastlund, M.D.**, senior manager and medical director; **David Therkelsen**, senior manager and director of marketing; and **Ken Kieffer**, senior manager and chief administrative officer.

Ophthalmic Medical Personnel Students Receive Scholarships

Three Minnesota students enrolled in the School of Ophthalmic Medical Technology at St. Paul-Ramsey Medical Center, a program for ophthalmic medical personnel, were among 25 students from around the nation to receive scholarships from the Joint Commission on Allied Health Personnel in Ophthalmology, Education and Research Foundation. **Tyler Olsby** of St. Paul, Minnesota, received the highest scholarship amount of the 25 students—$5,000 provided by the Otto Bremer Foundation of St. Paul. Two of the three students who received the next highest scholarships were also from Minnesota: **Yihong Clason** of Coon Rapids and **Alan Qualley** of West St. Paul each received $2,500, also provided by the Otto Bremer Foundation.

Places

HCMC Receives President's Award

Hennepin County Medical Center was one of three public hospitals nationwide to receive the highest honor of the National Association of Public Hospitals, its President's Award. The award recognizes innovative approaches to delivering high-quality care through the creation of integrated, coordinated health care delivery networks. NAPH President Larry Gage said that HCMC "through outstanding leadership ... has thoughtfully prepared and implemented an integrated health care delivery system that provides high-quality services from primary care to trauma care and has also developed a regional managed care system."

The other two recipients of the award are Contra Costa County Health Services in Contra Costa County, California, and the Denver Department of Health and Hospitals in Denver, Colorado.

Interactive Medical Journal

IVI Publishing in Minneapolis and the Mayo Clinic in Rochester have developed an interactive quarterly medical journal on CD-ROM called *Prime Practice* that offers opportunities to earn CME credits. Each issue, which will focus on a subspecialty area of interest to primary care physicians, will feature interactive case studies, a comprehensive resource library, and articles on the latest developments in the subspecialty. The contents are developed by Mayo Clinic physicians and reviewed by an advisory board of practicing primary care physicians. A year's subscription ($495) will offer up to 40 CME credits. The first issue—an update in cardiology—is now available; subsequent issues will focus on neurology, hypertension and vascular topics, and pulmonary medicine.

New Mayo Dialysis Center in Chippewa Falls

Mayo Clinic and Luther/Midelfort, part of the Mayo Health System, plan to develop a Mayo Dialysis Center in Chippewa Falls, Wisconsin, in the Midelfort Clinic office. The center, which is expected to open in early 1995, will include five dialysis treatment stations, a laboratory, and kidney dialysis support equipment. It is expected to provide services to a limited number of patients three days a week. Luther Hospital's dialysis

center will continue to see patients from its location in Eau Claire, Wisconsin, and will become part of the Mayo Dialysis System.

Methodist Hospital Begins Expansion

Methodist Hospital in St. Louis Park began a $5.7 million expansion of its Emergency Center and Endoscopy Department in September. The hospital is adding 5,076 square feet to existing space, bringing the total square footage to 19,190. The expansion includes increased capacity for critical care cases, a larger waiting room, more space for pediatric emergency care, a "safe" room to care for psychiatric patients, and more radiological capabilities for emergency x-rays.

Merged Children's Hospitals Announce New Name

The organization formed by the merger of Minneapolis Children's Medical Center and Children's Hospital of St. Paul is now called Children's Health Care. The 254-bed organization includes two hospitals: Children's-St. Paul and Children's-Minneapolis; a new ambulatory health services center called Children's-West; a pediatric unit at Fairview Ridges staffed by Children's employees, called Children's-Ridges; and foundations serving both hospitals. Children's Health Care has 2,400 employees, total patient revenues of about $229 million, assets of approximately $190 million, and a net worth of about $96 million.

The new Children's Health Care-West, a freestanding, hospital-affiliated pediatric ambulatory center in Minnetonka, opened its doors in late August. The center will offer same-day surgery, laboratory and radiology services, pediatric specialty examination services, and rehabilitation services, including physical therapy, occupational therapy, speech/language pathology, and audiology. Approximately 40 physicians will practice in the new center, and between 40 and 50 employees are expected to staff the center.

Treatment Facility Opens for Sexually Impaired Professionals

A new residential treatment facility for sexually impaired professionals opened in western North Dakota October 1. Milestones Treatment Center will provide both long- and short-term treatment of licensed professionals, such as physicians, health care professionals, clergy, and attorneys, who are unable to perform their vocations with reasonable skill and safety because of sexual impairment. Treatment will be provided for professionals who have sexually exploited patients or clients, professionals who are in danger of sexually exploiting patients or clients, and professionals suffering from social, emotional, or spiritual consequences that prevent effective practice. The program will include a therapeutic component in which all patients will participate in manual labor, such as cooking, woodworking, caring for horses, and community service.

HealthPartners Opens New Center, Plans Addition to St. Paul-Ramsey

HealthPartners has opened a freestanding one-day surgery center at Highway 280 and University Avenue in St. Paul that offers a variety of ambulatory outpatient surgical services, including obstetrical, gynecological, ophthalmologic, minor orthopedic, and dental procedures; ear tube insertions; and hernia repairs. The $3.6 million center will be operated and managed by St. Paul-Ramsey Medical Center, a division of HealthPartners. Group Health, Ramsey Clinic, and other community physicians and dentists using the center are expected to perform approximately 4,800 surgical procedures annually.

HealthPartners also announced in August that it plans to build a $21 million addition to St. Paul-Ramsey Medical Center that will include a medical office, another same-day surgery center, and a 24-hour urgent care center. George Halvorson, HealthPartners' president and chief executive officer, said he expects construction to begin in 1995.

Socioeconomics

MDH Receives Grant

Gov. Arne Carlson and Minnesota Commissioner of Health Mary Jo O'Brien announced that the Robert Wood Johnson Foundation has awarded the Minnesota Department of Health $777,245 to further develop primary health care opportunities throughout Minnesota. According to O'Brien, the grant will be used to help increase the number of primary care physicians and mid-level practitioners serving in medically underserved rural and urban areas throughout Minnesota. Carlson has designated the Minnesota Department of Health's Office of Rural Health and Primary Care as the lead organization in this project. It will work in cooperation with the Minnesota Center for Rural Health, a private, nonprofit organization.

It is anticipated that through this project, 35 physicians and mid-level practitioners will be placed in underserved areas in 1994-1995, 38 in 1995-1996, and 42 in 1996-1997.

MeritCare Affiliates With Allina and HealthPartners

MeritCare HealthSystems, a 260-doctor clinic based in Fargo, North Dakota, has developed affiliations with HealthPartners and Allina Health System. Both agreements will allow plan participants to see MeritCare doctors at its 29 clinic locations in 10 northwestern Minnesota communities and the Fargo area.

Allina, the first to announce an agreement with MeritCare, said its "strategic partnership" with MeritCare is intended to "enhance

health care delivery and clinical care management in ... northwestern Minnesota and North Dakota." A letter of intent signed by MeritCare and Allina calls for the further development of a regional integrated care network. MeritCare President Roger Gilbertsen said in a Minneapolis-based *Star Tribune* article that the goal is to "develop a structure to deliver health care services to North Dakota and western Minnesota."

Less than two weeks later, HealthPartners announced a "strategic alliance" with MeritCare allowing its patients to see MeritCare physicians. In a *St. Paul Pioneer Press* article, Gilbertsen said the HealthPartners agreement is less extensive than the Allina agreement; he said the contract with HealthPartners is similar to those it has with Preferred One and Blue Cross and Blue Shield allowing people insured through those companies to be treated by MeritCare physicians.

In another *St. Paul Pioneer Press* article, Brian Osberg, vice president of integrated service network and regional development for Allina, characterized the Allina/MeritCare alliance as "a true partnership to develop new managed care products in which Allina and MeritCare would share the risks and rewards of providing an integrated system of care."

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BCBSM Forms Subsidiary

Blue Cross and Blue Shield of Minnesota has formed a new subsidiary, Care Delivery Management, Inc., a company that will provide electronic data interchange and managed care services to health care providers. The subsidiary's electronic services will include claims processing, eligibility verification and referrals, transmission of x-rays and other diagnostic images, lab tests, medical policy guidelines, and medical outcomes.

Mayo Developing Family Practice Program in Des Moines

Mercy Hospital Medical Center in Des Moines, Iowa, the Mercy Clinics, and Mayo Graduate School of Medicine have agreed to develop a fully accredited family practice residency program in Des Moines. Starting in July 1997, six medical school graduates will attend the three-year family practice residency program each year. The organizations are developing the program to increase the number of family practitioners in Iowa.

MSP Streamlining Administrative Processes With Electronic Network

Minnesota Specialty Physicians, Inc., has entered into an agreement with MedPower, a Minneapolis-based health care information management company, to streamline administrative processes.

MedPower will implement a centralized processing system that will allow MSP's 13 specialty clinics to electronically submit claims to third-party payers, eliminating time-consuming forms and reducing the likelihood of human error. MedPower also will create an electronic network among MSP's member clinics—and eventually between MSP clinics and primary caregivers—developing functions such as common registration, referral management, and electronic messaging. Ultimately, the system will provide MSP a seamless registration process in which all MSP physicians will be able to access a patient's medical history on-line.

Medical Research

Control of Blood Sugar Reduces Kidney Damage in Diabetics

Researchers at the University of Minnesota have found that Type 1 insulin-dependent diabetics can help avoid kidney damage by maintaining strict control of their blood sugar levels, although such control increases hypoglycemic reactions, according to an article published in the August 24 *Journal of the American Medical Association*.

Researchers recruited 99 people with Type 1 diabetes who had received kidney transplants at the university and randomly assigned them to either maximal treatment or standard treatment. Maximal treatment consisted of regular monitoring of blood sugar levels and insulin injections whenever warranted. Standard treatment consisted of one or two daily injections of insulin. Researchers compared biopsies of the kidneys after five years with tissue samples taken at the time of implantation. The patients receiving maximal treatment had less kidney damage, but the researchers warned that they also experienced more hypoglycemic reactions—with several subjects lapsing into temporary comas, the longest lasting six days. In addition, the researchers said it is difficult for people to maintain tight control of their blood sugar levels, which can require three or four injections of insulin a day.

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Drug Relieves Hot Flashes While Avoiding Tumor Growth

Mayo Clinic researchers have found a drug that can relieve hot flashes in men whose testicles have been removed to prevent the spread of prostate cancer and in women who have been treated for breast cancer. Megestrol, sold under the brand name Megace, is a synthetic version of progestin and seems to reduce the severity and frequency of hot flashes in patients studied. Although estrogen can stop the hot flashes in women, doctors are concerned that the hormone could stimulate tumor growth in women treated for breast cancer. Androgen, a male hormone, can stop the flashes in men, but it would be counterproductive for men whose testicles have been removed to prevent androgen from spreading prostate cancer. Mayo physicians and doctors at more than a dozen other centers throughout the Midwest, known collectively as the North Central Cancer Treatment Group, monitored 163 patients in the study, which was reported in the August 11 *New England Journal of Medicine.*

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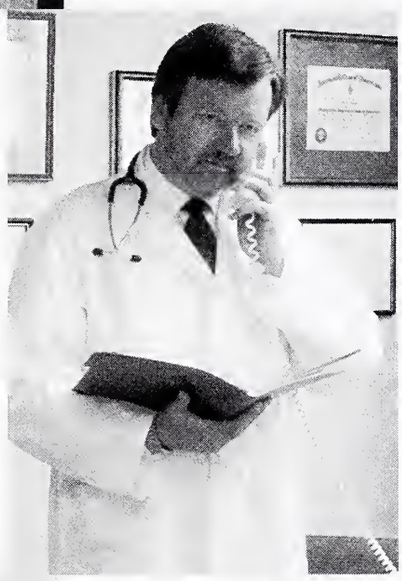

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Lyme Disease Reports Down

Reports of Lyme disease cases dropped 15 percent last year, according to federal health officials at the Centers for Disease Control and Prevention. Officials said that 9,677 cases of the disease were reported in 1992, while only 8,185 cases were reported in 1993. Officials say the decrease may partly be due to lack of reporting or misdiagnosing the disease. The states of California, Connecticut, Wisconsin, and New York accounted for 83 percent of the decrease. Lyme disease, transmitted by the deer tick, has been found in all states except Alaska, Arizona, Colorado, Mississippi, Montana, and South Dakota. MM

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December 2-3
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All programs are designed for primary care physicians and are Category 1 approved.
For additional information
or a program brochure call the
Hennepin County Medical Center
Office of Academic Affairs
701 Park Avenue Mailcode 869A
Minneapolis, MN 55415-1829
Phone 612/347-2075
Facsimile 612/347-2154

Hennepin County Medical Center
HCMC
Level I Trauma Center

OFFICE OF ACADEMIC AFFAIRS

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

OCTOBER 1994

Oct. 6-7 **Annual Forensic Science Seminar** Hennepin County Medical Center, Hennepin Faculty Associates-Office of Academic Affairs, and the University of Minnesota; Pillsbury Auditorium, Hennepin County Medical Center, Minneapolis, MN. CONTACT: Gail Kraemer, 612/347-2075, Ext. 2125.

Oct. 6-7 **Advanced Pediatric Life Support** Hennepin County Medical Center; Hennepin County Medical Center, Minneapolis, MN. CONTACT: Rachel Knudson, R.N., EMS Training, Hennepin County Medical Center, 701 Park Avenue South, Minneapolis, MN 55415; 612/347-3638.

Oct. 6-7 **Primary Care Emergencies** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Oct. 7 **Glaucoma Course** Allina; Phillips Eye Institute, Minneapolis, MN. CONTACT: Michelle Hemingway, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/336-5061.

Oct. 7 **Managed Mental Health Care: Principles and Techniques for Practice** University of Minnesota; Mall of America-Grand Hotel, Bloomington, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Oct. 7-8 **Nursing Home Medical Directors** University of Minnesota; Sheraton Midway, St. Paul, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Oct. 7-8 **Family Practice Update** Hennepin County Medical Center, Hennepin Faculty Associates-Office of Academic Affairs, and the University of Minnesota; Mall of America Grand Hotel, Bloomington, MN. CONTACT: Ann Samways, CME Coordinator, 612/347-2078; or Robin Hoppenrath, Manager, Office of Academic Affairs, 612/337-7128.

Oct. 8 **Current Trends in Ophthalmology** Allina; Hotel Sofitel, Bloomington, MN. CONTACT: Michelle Hemingway, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/336-5061.

Oct. 12-14 **Internal Medicine Review** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Oct. 12-15 **Thoracic Organ Transplantation** Minneapolis Heart Institute Foundation; Westin La Paloma, Tucson, AZ. CONTACT: Don Young, 2810 57th Avenue North, Minneapolis, MN 55430; 612/574-7982.

Oct. 13-15 **Annual Orthopedic and Trauma Seminar** Hennepin County Medical Center, Hennepin Faculty Associates-Office of Academic Affairs, and the University of Minnesota; Pillsbury Auditorium, HCMC. CONTACT: Laura Carroll in Orthopedics, Hennepin County Medical Center, 612/347-2075, Ext. 3736.

Oct. 13-15 **Nineteenth Annual Fall Continuing Education Seminar** Minnesota Academy of Physician Assistants; Best Western Apache, Rochester, MN. CONTACT: Sonja L. Heiniger, 11794 Akron Avenue East, Inver Grove Heights, MN 55077; 612/552-8876.

Oct. 14-15 **Cutaneous Laser Surgery** Allina; Abbott Northwestern Hospital, Minneapolis, MN. CONTACT: Don Young, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

Oct. 15 **Managing Cancer Pain: Knowing Is Not Enough** Allina; Lutheran Brotherhood Conference Center, Minneapolis, MN. CONTACT: Annette Carlson, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7910.

Oct. 15-16 **International Symposium on Myeloproliferative Disorders** Mayo Foundation; Siebens Medical Education Building, Rochester, MN. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 507/284-2509.

Oct. 16 **Problem Solving in Hypertension** Mayo Foundation; Mayo Foundation, Rochester, MN. CONTACT: Registrar, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Oct. 17-21 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.

Oct. 20-23 **Mechanical Ventilation: Principles and Practice** University of Minnesota; Radisson Hotel-St. Paul, St. Paul, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Oct. 21 **1994 Diabetes Conference** Duluth Clinic and St.

Mary's Medical Center; Duluth Entertainment Convention Center, Duluth, MN. CONTACT: Rockie Odberg, Duluth Clinic, 400 East Third Street, Duluth, MN 55805; 218/725-3838.

Oct. 21 **Third Annual Conference for CME Planners** Minnesota Medical Association; Northland Inn, Brooklyn Park, MN. CONTACT: Jane Phillip, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875 or 800/999-1875.

Oct. 23-27 **Advances in Diagnostic Radiology** Mayo Foundation; Sea Island, GA. CONTACT: Rita Kunz or Jan Fleck, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Oct. 24-25 **Advanced Trauma Life Support (ATLS)** Allina; United and Children's Hospital Conference Center, St. Paul, MN. CONTACT: Annette Carlson, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7910.

Oct. 26-29 **American Society of Nephrology/Nephrology Issues in the '90s** University of Minnesota; Orlando, FL. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Oct. 27-28 **Annual Fall Seminar: Obstetrics and Gynecology** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Oct. 27-28 **Trauma Management for Primary Care Providers** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Oct. 28 **ECG Conference** Hennepin County Medical Center, Hennepin Faculty Associates-Office of Academic Affairs, and the University of Minnesota; Mall of America Grand Hotel, Bloomington, MN. CONTACT: Ann Samways, CME Coordinator, 612/347-2078; or Robin Hoppenrath, Manager, Office of Academic Affairs, 612/337-7128.

Oct. 28-29 **New Ulm Fall Seminar** Allina; Holiday Inn, New Ulm, MN. CONTACT: Don Young, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

Oct. 29 **Update and Case Reviews in Otorhinolaryngology—Head & Neck Surgery** Mayo Foundation; Mayo Foundation, Rochester, MN. CONTACT: Registrar, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Oct. 29 **Eighth Annual Tutorial on Pediatric Cardiology for the Primary Practitioner** The Children's Heart Clinic; Children's–Minneapolis, MN. CONTACT: David Burton, M.D., 2545 Chicago Avenue South, #106, Minneapolis, MN 55404; 612/871-4660.

Oct. 30 **Problem Solving in Hypertension** Mayo Foundation; Mayo Foundation, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

NOVEMBER 1994

Nov. 2 **Annual A. B. Baker Dinner Lecture** Hennepin County Medical Center, Hennepin Faculty Associates-Office of Academic Affairs, and the University of Minnesota; Whitney Hotel, Minneapolis, MN. CONTACT: Ann Samways, CME Coordinator, 612/347-2078; or Robin Hoppenrath, Manager, Office of Academic Affairs, 612/337-7128.

Nov. 3-4 **Mayo Clinic Ob/Gyn Clinical Reviews** Mayo Foundation; Mayo Foundation, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Nov. 3-5 **Annual Nutrition Symposium** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.

Nov. 4 **Beyond Broken Bones and Black Eyes. Can You Identify Abuse? How Will You Respond?** Minnesota Medical Association, Hennepin County Medical Society, and Ramsey County Medical Society; Radisson South Hotel, Bloomington, MN. CONTACT: Cathy Graci, Ramsey County Medical Society, 3433 Broadway Street NE, Suite 350, Minneapolis, MN 55413-1761; 612/362-3704 or 800/999-1875.

Nov. 4 **Genes and Cancer (Cancer Center Annual Symposium)** University of Minnesota; Mayo Auditorium, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Nov. 4 **E.T. Bell Symposium: Advances in Hematopathology** University of Minnesota; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Nov. 4-5 **Front Line Neurology: Primary Care Management of Patients with Neurological Problems** Allina; Marriot City Center, Minneapolis, MN. CONTACT: Don Young, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

Nov. 4-6 **After Everyone Leaves: Preparing for, Managing, and Monitoring the Mid- and Long-term Effects of Large-Scale Disasters** University of Minnesota; Radisson South Hotel, Bloomington, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Nov. 6 **Audiology Videoconference** Mayo Foundation and Sheldon Reese Foundation; Mayo Medical Center, Rochester, MN. CONTACT: Mayo Foundation, Postgraduate Courses, Section of CME, Rochester, MN 55905; 507/284-2509 or 800/323-2688.

Nov. 10-12 **Strategies in Primary Care Medicine** St. Paul-

Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Nov. 11-13 **Clinical Mycology** Mayo Medical Laboratories; Mission Inn, Howey-In-the-Hills, FL. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Nov. 12-13 **Monitoring Neural Function During Surgery** Mayo Foundation; Mayo Foundation, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Nov. 13 **Exercise Gas Exchange in Heart Disease** University of Minnesota; Dallas, TX. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Nov. 13-14 **Building Families: Ethical and Policy Issues in Adoption** University of Minnesota; Hotel Sofitel, Bloomington, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Nov. 17-18 **Breaking the Cycle of Violence** St. Paul-Ramsey Medical Center; Holiday Inn International Airport, Bloomington, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

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The MMA Committee on Accreditation and CME has recently reaccredited the following CME sponsors:

- ❧ Fairview Riverside Medical Center, Minneapolis
- ❧ Fairview Southdale Hospital, Edina
- ❧ Group Health Foundation, Bloomington

For more information on the MMA accreditation program, please call Jane Phillip at the MMA, 612/378-1875 or 800/999-1875.

North Medical Programs

A Department of North Memorial Medical Center

The Trauma Symposium
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North Memorial Medical Center

This year's program is loaded with practical suggestions, proven tips and workable solutions to those tough challenges in providing trauma care. You won't want to miss:

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- Obstacles to Trauma Care
- Shock Resuscitation: How Much is Enough?
- Five Most Common Mistakes in Packaging the Patient for Stabilization and Transport
- Providing Trauma Care: Is It Hazardous to the Physician's Health?
- Avoiding Common Pitfalls in Trauma
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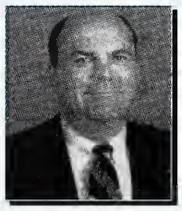

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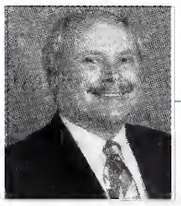

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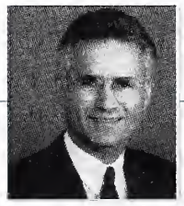

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- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

General Surgeon, Family Practice, Ob/Gyn, Internal Medicine to join progressive 13-physician group practice. Rural college town 30 miles from St. Paul, Minnesota. New clinic and new hospital. Contact: Robert B. Johnson, M.D., River Falls, WI 54022; 715/425-6701. (*5/94-R)

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Mankato Clinic, Ltd. is seeking additional BC/BE physicians in the following specialties: orthopedics, radiology, invasive cardiology, oncology/hematology, family practice, and general internal medicine. The Mankato Clinic is a 59-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. M. P. Wheeler, President, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (10/93-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

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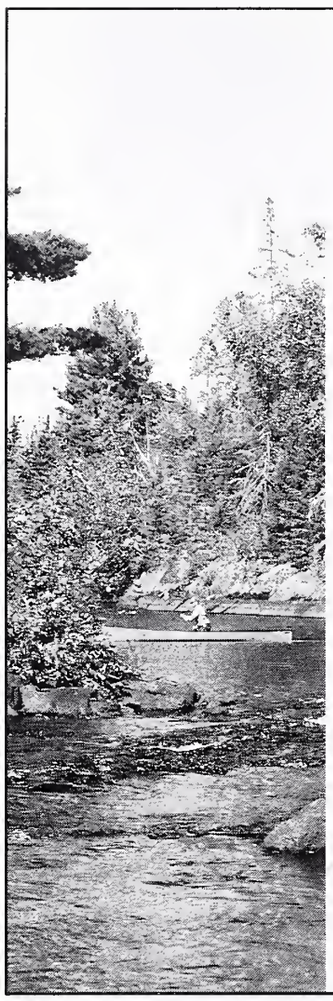
Olmsted Medical Group is seeking BC/BE physicians in the following specialties: emergency medicine and ob/gyn. Great opportunity for well-trained physicians to join a 70-physician multispecialty group in a dynamic, progressive practice. In addition to the main office in Rochester, the group operates eight branch offices in southeastern Minnesota. Excellent salary/benefits package includes malpractice insurance, flexible benefits plan, 401(k) and profit sharing, and relocation assistance. Send CV to Olmsted Medical Group, Attn: Susan Schuett, 210 Ninth Street SE, Rochester, MN 55904. (1/92-R)

Internal Medicine and Dermatology practice opportunities available at the Faribault Clinic. The Faribault Clinic is a multispecialty group practice of 18 physicians. Faribault is located 50 miles south of Minneapolis on I-35. For more information contact Ray W. Wood, M.D., or Ken Smith, Administrator, 924 NE First Street, Faribault, MN 55021; 507/334-3921. (4/94-R)

Stillwater: 20-physician multispecialty group with emphasis on primary care seeking BC/BE family physician. Scenic location with excellent school system, supportive medical community with strong local hospital, competitive salary and benefits. Send CV to Jon Pedersen, St. Croix Valley Clinic, 921 South Greeley, Stillwater, MN 55082; 612/439-2215. (9/93-R)

Mora, Minnesota: Aggressive, young, seven-physician family practice group seeks to add one or two physicians. Mora is a friendly community located one hour north of Minneapolis/St. Paul. There is abundant outdoor recreation in the area, including Mille Lacs Lake. The town is host to the Vasaloppet Ski Race, a half-marathon, canoe race, and bike race. If you are interested in this practice opportunity, and you should be, please contact Peter J. Donner, M.D., Mora Medical Center, Ltd., Mora, MN 55051; 612/679-1318 (wk); 612/679-1981 (hm). (11/92-R)



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Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

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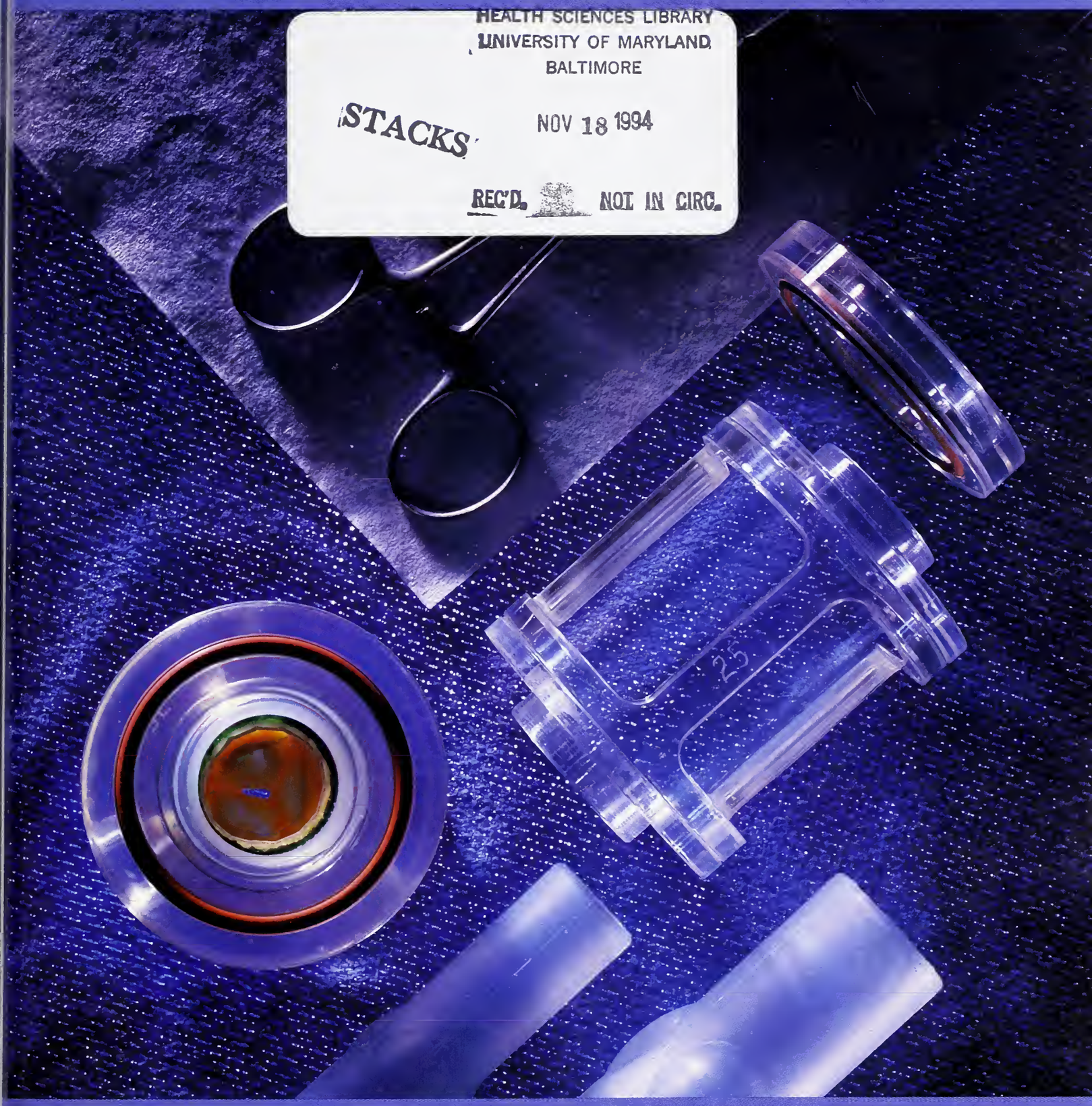

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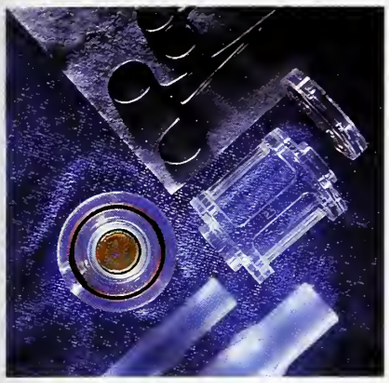

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A Medtronic freestyle stentless aortic root valve is displayed in one of its customized testing-procedure holders. Photo courtesy of Medtronic, Inc.

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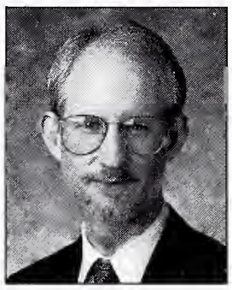

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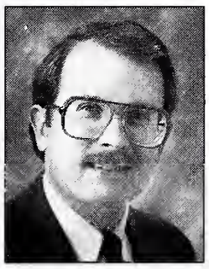

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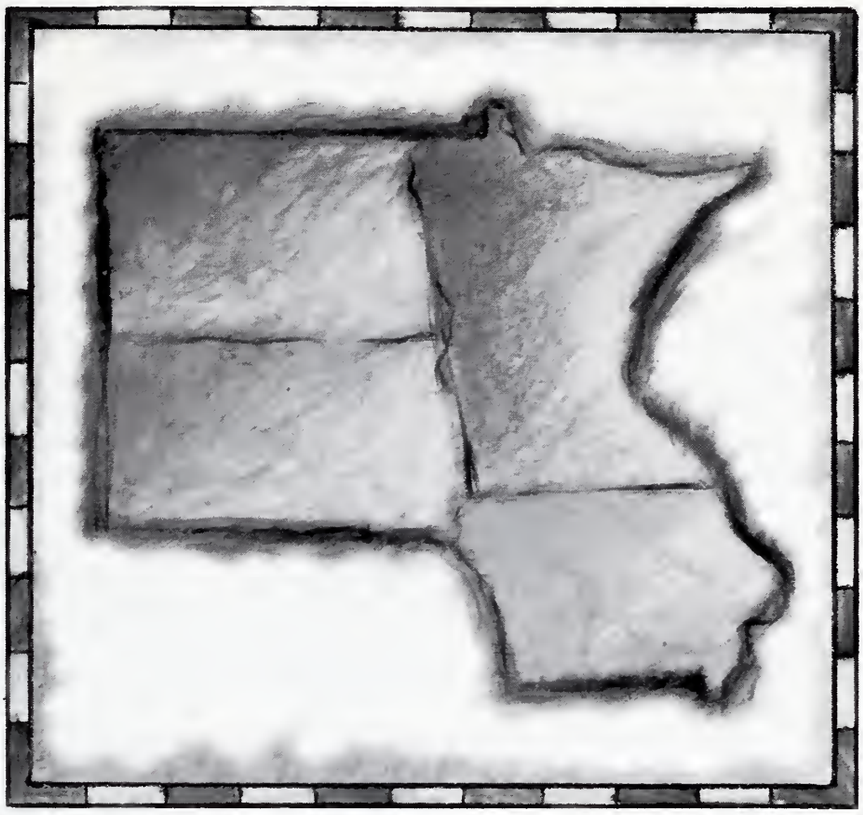

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Rational Rationing

When the Bucks Stop Here

Charles R. Meyer, M.D.

What can we afford? Whether shopping for groceries or looking for a new house, this is a question we all ask daily. Yet we quickly move from mundane accounting to uncomfortable ethical choices when we ask the question about our own health. In fact, it is so uncomfortable that we look for words like "resource allocation" to soften the mental images evoked by the word rationing. Nonetheless, the question must be asked. To paraphrase an oft-paraphrased campaign slogan, "It's the bucks, stupid," and we need to figure out how to spend our health care buck more wisely.

Undaunted by the "R" word, this month's *Minnesota Medicine* tackles rationing and resource allocation. We look at what should be paid for, how we should decide which technology is worth buying, and how Minnesotans feel about these difficult choices.

Following Moses' lead, I have condensed the truth about rationing into 10 pithy statements:

1. *The bucks are limited.* The "we can do it all" mentality died with the Great Society and the Apollo moon landing.

2. *Waste happens.* Estimates vary, but everyone agrees that inappropriate care, fraud, and excessive administrative costs contribute unnecessary billions to health care.

3. *Vacuuming up waste will not clean up the whole house.* In a July 1994 *JAMA* article, David Eddy examined health care costs, assessed the impact of waste, and found that a quick cleanup—of the drug companies, fat administrators, and rapacious doctors—won't begin to solve our fiscal dilemma.

4. *One person's waste is another's water.* Like an obsessive-compulsive garbage collector, Eddy catalogued waste and found that, except for the most blatant "harmful waste," most discussions about eliminating waste will provoke honest debate about whether that "waste" should be eliminated.

"What we want for society and what we want for *me* are not always consistent."

5. *Expensive new gadgets will need to be worth it.* Developing technologies will have to pass more rigorous fiscal and scientific tests.

6. *Bill-payers will sit on the throne until dethroned.* So far, HMOs, insurance companies, Medicare, and Medicaid have handed down fiats about what they will pay for. Even if their decisions have scientific or cost-benefit validity, they frequently arrive late. In recent years, Medicare's endorsement and coverage of Pap smears emerged with all the currency of a 1990 press release on the development of the Model T.

7. *Medical schools will need to teach buck balancing in addition to biochemistry.* Although doctors have not ignored cost, the current integration of cost into clinical decisions will need to be re-emphasized and systematized with clinical decision tools and guidelines.

8. *Doctors will still be doctors, but it will be different.* Doctors have been, and should always be, advocates for their patients. But "doing everything" for your patient will change and, like all changes, it will be difficult.

9. *People like having their cake and eating it, too.* Miles' and Bendiksen's report reveals many irrational attitudes toward rationing. As patients and doctors, what we want for society and what we want for *me* are not necessarily consistent.

10. *We all need to decide what we want.* Beneath all the cost-containment, appropriateness, and cost-benefit hubbub lies the disturbing fact that we asked for the current mess. We demanded the high-quality, high-cost medicine that we have today. And now that it is bankrupting us, we need to re-examine what we want.

No one has stated this more eloquently than the Hasting Center's Daniel Callahan. In a June 1990 *NEJM* editorial, he wrote: "We cherish the idea of limitless medical progress, which has come to mean that every disease should be cured, every disability rehabilitated, every health need met, and every evidence of mortality, especially aging, vigorously challenged."

This attitude not only won't work in our limited resource world, but it also raises medical science to near-deity status. Conquering every malady for every patient has never been possible and won't be in the foreseeable future. To answer rationing's tough questions, we don't need enthroned HMOs, omniscient government, or god-like medicine men making rules about what gets paid for. We need to ask what we want medical progress to do for our lives and then find the bucks to buy it. MM

Oregon Physician Make Health Care a Political Priorit

John Kitzhaber, M.D., combined his talents in medicine and politics to author and pass the widely debated Oregon Health Plan.

. . . . . .

By Mark Gibson

Dr. John Kitzhaber begins his day at 5:30 a.m. with a quick cup of co and a glance at a daily schedule that includes no rounds, no call rotati and no office visits. Rather than patient charts, he consults his brief book and reviews the issues on which he must be particularly w informed during this day of campaigning for his state's highest elec office.

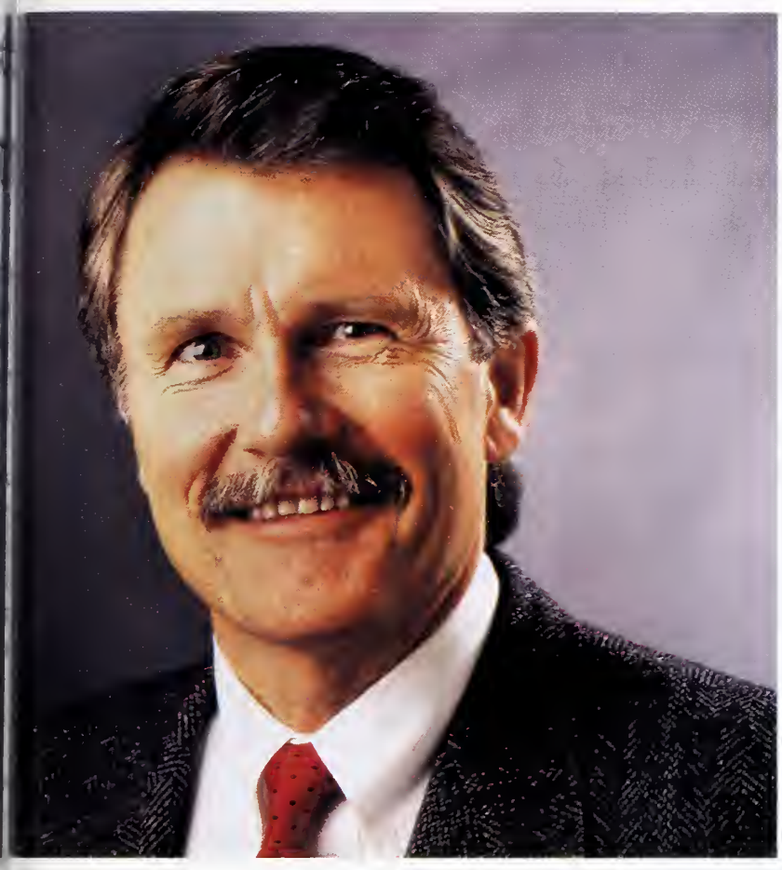
The day's first stop is an early childhood education and day-c center. Next, he tours the tribal health care facility run cooperatively the Bureau of Indian Affairs and the Warm Springs Tribe. Kitzhab who has a reputation for being easygoing and relaxed, is clearly at ho discussing in-depth the treatment capabilities of the clinic, as well as clinic's experience in utilizing the Oregon Health Plan. There seems be an air of nostalgia about him as he lingers for a moment in emergency receiving area, but he's soon off to a series of meetings discuss tribal fishing rights and gambling.

Politics and medicine are the cornerstone of a life packed w achievement and marked by occasional controversy. At the age of Kitzhaber has practiced medicine for 15 years and served in the Oreg Legislature for 14 (eight as president of the Senate). He has autho and passed one of the most widely debated pieces of legislation in rec history, the Oregon Health Plan; he has become an internationa renowned lecturer and writer on health policy; and, as *Minnes Medicine* goes to press, he is Oregon's leading candidate for govern

Kitzhaber's interest in both medicine and politics started ea While still in high school, he built a heart-lung machine, and then, w the cooperation of a local slaughterhouse, he carried out a series experiments that demonstrated it worked. "I'd show up at the slau terhouse with a gallon jar and a little vial of anticoagulant," he says. " collect the blood and store it for later. Then I'd have to run like cr to make my first-period math class," he recalls. "I can't imagine w my math teacher must have thought when I'd show up in the morni taped horn-rimmed glasses askew and spattered with cows' blood.

Kitzhaber credits his parents with fostering his early interest politics. His father, an English professor specializing in writing, brou an insistence on logic and persuasion to family discussions. His moth always active in local government and the League of Women Vote instilled a deep appreciation for self-government and civic involveme

While attending the University of Oregon Medical School, Kitzh er did not regard these two interests as mutually exclusive. At a ti when most of his peers were making medicine their primary focus, placed a wider social context on the experience. He brought speak to the campus to debate issues of the day and ran (unsuccessfully) to a delegate to the Democratic National Convention.



"We wanted to begin allocating our resources in ways that would maintain and improve the health of Oregonians to the greatest extent possible."

–*John Kitzhaber, M.D.*

Kitzhaber began his medical practice in Roseburg, a all southern Oregon timber town located on a world-nous fly-fishing stream, the North Umpqua River. Be-ise he worked in 24-hour shifts as an emergency physi-n, his days off were unencumbered by call rotation or spital rounds, and he quickly expanded his political ivities. In 1978, he was elected to the Oregon House of presentatives, unseating an incumbent Republican.

Throughout this first campaign, issues relating to the vironment and education dominated the debate, and alth care was only a peripheral issue, partly because the sis in cost and access wasn't as acute in 1978 and partly cause Kitzhaber chose not to make it a mainstay of his npaign. "I think being a doctor was helpful in that first npaign because I believe people still respect our profes-n for the most part," Kitzhaber says, "but clearly, health e was not the compelling issue it has become today."

His ability to deal with the full scope of public policy ues made Kitzhaber an unusually effective legislator and is a primary reason he assumed the mantle of leadership early in his career. "John has always carefully prioritized ues by their importance," says Bill Bradbury, a state nator and long-time Kitzhaber ally. "He has never over-played the importance of health care just because he is a physician. He understands that if we kill the planet, all other questions are moot. He also understands that a healthy economy is what enables us to buy services such as health care, and he has always viewed education as the long-term key to a successful economy."

This integrated view of public policy issues lies at the heart of what many consider Kitzhaber's crowning legislative achievement, the Oregon Health Plan (see sidebar, page 30). Kitzhaber's involvement with developing the plan followed one of the most painful debates in his career. In 1987, the Oregon Legislature voted to delete funding for major organ transplants for poor Oregonians, while simultaneously moving substantial additional money into prenatal and infant care for the same populations. Even though the original decision was not particularly controversial, a firestorm of criticism erupted when the policy denied a bone marrow transplant to a 7-year-old boy with leukemia.

While Kitzhaber had little to do with the original decision, he defended it as a short-term public policy. However, mindful of its shortcomings, he immediately went to work creating the Oregon Health Plan (OHP) to fill what he considered a major policy void regarding health care resource allocation. He broadened the discussion to include all health care services, rather than simply focusing on organ transplants; and he included all populations, not just Medicaid recipients. Moreover, he insisted on broadening the debate to include not just health care services, but also other services with an impact on health.

In typical Kitzhaber fashion, he began by defining the overall goal of his prospective reform and by assembling a political coalition to support it. "We didn't simply want to buy health insurance for Oregon's needy," he says. "We wanted to begin allocating our resources in ways that would maintain and improve the health of Oregonians to the greatest extent possible. Our objective was health, not just

KITZHABER continued on page 30

Let's not delude ourselves; rationing is happening already, but it can be minimized.

Time to Confront Health Care Rationing

BY STEVEN A. SCHROEDER, M.D.

ILLUSTRATION BY BRUNO PACIULLI

A question often heard in the debate about health system reform is whether it will be possible to achieve significant cost savings without rationing health care services. This is the wrong question. Health care rationing already occurs in the United States and in every other country, as well.

There are at least eight explicit and implicit categories of health care rationing. Here are examples of rationing types, starting with the explicit:

• By age. This occurs most notoriously in the United Kingdom, where, for example, people over the age of 55 rarely receive hemodialysis for kidney failure. Even in the United Kingdom, rationing by age is not discussed openly but is a mutual understanding among physicians stemming from a sense of finite resources and infinite demand.

• By prognosis. Rationing by prognosis—selecting for treatment those with the best chance of responding to care—is a common feature of medical practice in Europe. In the United States, it has been limited to conditions such as third-degree burns where it is known with a great degree of precision that injury over a certain percentage of the body invariably proves fatal. The frequency with which clinical decisions are challenged by lawsuits in the United States is one reason why rationing by prognosis is not common here.

• By coverage. This is the most common form of explicit rationing in this country. Most health insurance plans omit certain forms of medical care, such as cosmetic surgery. Plans often limit benefits, such as the number of hospital days or home care.

• By scarcity. In the United States, rationing by scarcity occurs most often among insured patients when the intensive care unit is filled. In those cases, the prognosis usually determines who gets the next bed. In all nations, of course, the scarcity of available organs for transplant results in rationing.

There are also examples of implicit rationing:

• By budget. The demand for medical care typically exceeds the supply. In the United States, health maintenance organizations constrain supply more than in the fee-for-service sector. Waits are common, although much shorter than in the United Kingdom. The constraints result because the capitation payments that finance many HMOs set a budget for the organization, in contrast to the open-ended nature of fee-for-service funding.

• By price. This is the most common form of implicit medical care rationing in the United States. It is not used as often in other developing countries. People without medical insurance clearly face rationing by price. Those with insurance face it when services such as most nursing home care, cosmetic surgery, and infertility treatment are not covered under their health insurance plan.

• By queue. Rationing by queue occurs commonly in other countries because of budget constraints. This postpones consumption of the service being rationed, such as a diagnostic test or elective surgery. The extent of waiting lists for surgery in Canada and elsewhere and the hardships imposed by such delays are commonly cited in current debates. In the United States, rationing by queue takes place most commonly through two circumstances—HMOs and organ system transplants.

Thus, the question is not whether rationing will occur. It is already here. Our goal should be to minimize rationing by using resources as efficiently and equitably as possible. The American public needs to educate itself to make fair and difficult choices about the consumption of health care because no nation, not even one as wealthy as ours, can afford to pay for all the health care the public would like to consume.

The United States has difficulty confronting health care rationing. We have deluded ourselves by rationing—for the most part—implicitly, while contending that rationing occurs in other countries, not in our own.

As the escalating costs of medical care tear at the veil that covers our rationing processes, we face the need for openly discussing difficult choices. It's time to start that conversation. MM

Steven Schroeder, a general internist, is president of the Robert Wood Johnson Foundation of Princeton, New Jersey, a nonprofit health care philanthropy.

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Minnesota is a leader in medical technology, with hundreds of companies creating products and jobs. Will health system reform put innovation—and maybe our economy—at risk?

Taking the Pulse of Medical Technology

By William Hoffman

Innovation in medical technology was simpler in the beginning. Just six weeks after pioneering open-heart surgeon C. Walton Lillehei described what he had in mind to his electronics repairman, Earl Bakken, he was holding the first wearable, battery-powered pacemaker.

Bakken had modified a metronome circuit design he found in *Popular Electronics*, matching the rhythmic pulse it produced to the human heartbeat. Within three years, Bakken's company, Medtronic, was selling implantable pacemakers for $375 each. That was 1960.

But medical miracles no longer happen the old-fashioned way. Government regulation has done the most to change that, bringing with it strict standards of safety and efficacy and lots of costly delays and red tape. Today medical technology is blamed for contributing in a major way to the rising costs of health care, which now consumes nearly 15 percent of the federal budget, three times more than in 1960. Health system reform initiatives could add to already burdensome regulation, threatening that delicate human element—the willing-

Medtronic chemical engineer Paul Wu checks the equipment used to attach anti-thrombogenic Carmeda surface to perfusion circuit components produced by Medtronic Cardiopulmonary. Photo courtesy of Medtronic, Inc.

ness to take risk, without which innovation itself goes on the critical list.

"Today the innovative process is long and costly," says Paul Citron, vice president of science and technology at Medtronic, Inc. "It takes 10 to 15 years and millions of dollars from the 'gleam in the inventor's eye' for a product to reach the marketplace. Each step in the process is taking longer and longer."

In the beginning, taking the invention of the pacemaker as an example, the number of unknowns was enormous. But a surgeon and an engineer, exercising their best judgment, came up with a plausible approach to remedy a life-threatening condition. "The technology turned out to be clearly beneficial to the patient," Citron says. "You can't get a critical technology to a patient in anywhere near that speed today. And there is a price to be paid for moving too slowly."

Earl Bakken working in his garage during the 1950s. Photo courtesy of the University of Minnesota.

It is ironic that the tide of health system reform is sweeping across the country and around the world at a time when more people are living longer with a better quality of life, Citron says. "Mean survival continues to move up every year. Medical technology has played a direct role in restoring patients to full and more productive lives. And that's the right role."

Also ironic, in Citron's view, are the expectations people have of medical technology. "These therapies are used in situations where the most ideal system—the body's own—has failed. Yet we expect medical technologies to perform flawlessly. That's asking a lot."

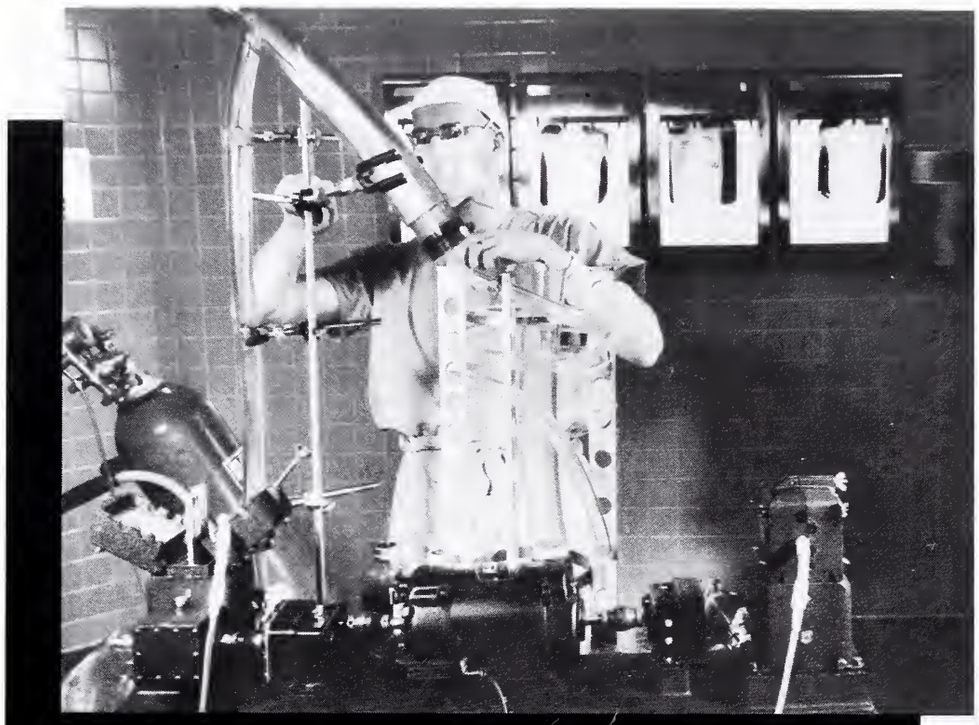
People associate advanced medical technology with high-quality medicine. Medicine, in turn, has become increasingly dependent on new technology for its clinical and prestige value. It is no accident that Minnesota has a long and illustrious history in the development of high-quality health care and medical technology, and the state has much at stake economically. Figures from the state Department of Trade and Economic Development and Medical Alley, a regional trade association of health care product manufacturers, tell the story.

State's Medical Device Industry Impressive

Health care manufacturing is one of the state's largest and fastest growing economic sectors, growing twice as fast as overall manufacturing and twice as fast as health care manufacturing nationally. The state's medical device production totaled approximately $1.6 billion in 1993. Minnesota is second to Delaware in concentration of medical manufacturing employment and is second in the proportion of the workforce employed in the medical device industry. Growth in employment among the 200 some medical manufacturers is twice the national average, and most of the jobs are relatively high paying. Minnesota ranks high in the number of new medical device companies established each year, and it exports 50 percent more medical products than other states.

New figures from the Health Care Technology Institute, a Washington, D.C.-area research organization, show that 14,231 Minnesotans were employed in the health care technology industry in 1992, the fourth highest nationally and representing growth of 5.4 percent over the previous year. State income tax revenues from these employees totaled nearly $24 million, fifth highest nationally.

The investment picture has been equally impressive. A study prepared for Minnesota Technology, Inc., a



The helical reservoir bubble oxygenator, introduced in 1955, and its inventor, Richard DeWall. Photo courtesy of U of M.

nonprofit corporation established to assist the state in becoming more competitive, shows that in 1993 the medical device industry accounted for the lion's share of venture capital investment in the state. At $34.8 million, investment in the industry was 36 percent of all capital investment in Minnesota, compared with a national average of 10 percent for medical devices and equipment. And while medical technology investors were cutting back nationally, Minnesota firms were reporting a 20 percent increase for 1992-93.

But that was then. Today investors are "nervous as all get out," says Arthur Kydd, president of St. Croix Management Group Ltd., a medical-venture capital investment firm in Minneapolis. "Health care reform is contributing in a big way to the general feeling of uncertainty."

Now, medical venture investment firms "are having one helluva time raising money," Kydd says, adding that surgeons, cardiologists, and other physicians who have been among the most active investors are shying away, even from promising cardiovascular start-up opportunities. "Investors are taking a 'wait-and-see' approach. This is true all the way up the chain—to the investment bankers. It's a terrible time for public and private financing," Kydd says.

But that could change, too. "Next year it could be completely different," he says. Health care legislation could turn out to be "innocuous" to the industry, giving investors on the fence the impetus they need to risk their money; or the uncertainty "could linger on for a long time."

Fact or Fiction? Technology Main Culprit in Rising Costs

Is medical technology really the main culprit in rising health care costs? "That may have been true five or 10 years ago, but new medical devices are developed with serious consideration of costs," says a well-connected consultant who asked not to be named. "Manufacturers have to look more closely at what the market will bear. It used to be that you could add technology, boost the price, and hype the product as value-added. But you can't raise the price if no one will buy the product."

Fancy new instruments or systems typically go through a turbulent, roller-coaster period of fierce competition, high-pressure sales, erratic pricing, and inadequate training of users, says this industry watcher. A recent example is the crash of the market for laparoscopic surgical instruments after a frenzied boom a few years ago. The market is now on the rebound, but surgeons and hospital administrators are much more cautious, requiring proof of economic as well as clinical efficacy from manufacturers before making a purchase. "This happens all the time because of the free-market system. We end up paying for the 'overshoot.' But if we impose controls, we would not be able to innovate. It could take 10 years instead of a few years to get sorted out." By then, the consultant says, the best products would bear the names of foreign firms.

How much is medical technology contributing to the rise in health care costs? Experts agree it does contribute, but figuring out how much is frightfully complex. That complexity is not done justice by news media stories that focus solely on powerful and expensive diagnostic imaging equipment and its proliferation from large urban health care centers to community hospitals and clinics.

Two recent studies commissioned by the Health Care Technology Institute (HCTI), a nonprofit organization formed by the Health Industry Manufacturers Association, show that medical technologies—medical devices,

pharmaceuticals, and medical procedures—contribute between 11 percent and 15 percent of the annual increase in U.S. health care costs. General inflation, which has afflicted health care like a plague, accounts for half of the annual increase; 20 percent is due to health services price increases that exceed general inflation; and 10 percent is due to population growth. Calculations were based on data from the Health Care Financing Administration. The costs of purchasing and using technology were analyzed, as were technologies that increase costs, decrease costs, and cost the same as other alternatives.

Although the long-term impact of the studies remains to be seen, they have been well received, "particularly by people outside the industry, and that's very important," says Candace Littell, HCTI director. The studies were conducted by Health Economics Research, Inc., of Waltham, Massachusetts, and the Project HOPE Center for Health Affairs in Bethesda, Maryland, both independent research organizations.

Health Reform Threatens Innovation

Many physicians, politicians, and manufacturers question whether health system reform and the regulations it brings will undermine innovation. In the July-August issue of the *Harvard Business Review*, Harvard economists Elizabeth Teisberg and Michael Porter and investment executive Gregory Brown, a former surgeon, write: "The national debate defines technology as the enemy and focuses on how to cut fat and eliminate waste in the current system with reforms like health plan buying alliances, consolidated networks, and price caps on drugs and devices. ... In fact, overconsolidation of networks and price restraints on or biases against new drugs and devices will undermine incentives for innovation."

Pharmaceutical, biotechnological, and medical device companies "are beginning to deliver cost-reducing innovations," they write, adding that health system reform "must build on this progress by creating still stronger incentives for both medical and managerial innovation." Innovation, they argue, is the "missing principle" in the current health system reform proposals and "the only true, long-term solution for high-quality, affordable health care."

That principle is echoed by Rep. Jim Ramstad, R-Minnesota, who has made medical technology innovation his rallying cry. A year ago, Ramstad and Tim Valentine, D-North Carolina, formed a "Medical Technology Caucus" in the U.S. House of Representatives. "As Congress reconstructs our health care system, it is critical to improve the ability of our researchers and entrepreneurs to bring to market life-saving and cost-saving technologies," says Ramstad in a news release from his Washington, D.C., office.

Most of the recent health system reform proposals considered by Congress would have harmed innovation, in Ramstad's view. In September he said he was "relieved that the government-directed, regulation-heavy" pro-

Neil Heraly has worked for Medtronic since 1958, so, when faced with life-threatening ventricular tachycardia, he had no reservations about receiving a Medtronic PCD (pacer/cardioverter/defibrillator) system as part of a clinical evaluation program at the University of Minnesota. Photo courtesy of Medtronic, Inc.

"The national debate defines technology as the enemy. ... Biases against new drugs and devices will undermine innovation."

–*Harvard Business Review*

posals of President Clinton, House of Representatives Majority Leader Richard Gephardt, D-Missouri, and Senate Majority Leader George Mitchell, D-Maine, have been declared dead for this year. The plans would "severely damage the potential for further advancement of medical technology. Rigid price controls and a strictly defined mandated benefits package would hinder innovation and lock us into existing technology for years to come," says Ramstad.

Susan Foote, senior health legislative assistant to Sen. David Durenberger, R-Minnesota, and a national expert on medical device regulation and innovation, says there is a natural tendency for government bureaucracies "to move in a regulatory direction," which in turn diminishes the creativity and dynamism of the private sector. Federal or state health system reform policies that define strict benefits packages will have a difficult time "resisting expansion into price controls," she says.

In a commentary titled "Technology and Health Reform: A Legislative Perspective" published in the summer 1994 issue of *Health Affairs*, Durenberger and Foote argue that current policies encourage costly overuse of technology and that the marketplace is best equipped to make needed reforms: "In a medical market, the creative and effective use of technology will distinguish successful [health] plans from unsuccessful ones. Let plans compete on how well they use technology to produce value."

Expressions of concern, worry, anxiety, even panic can be heard along Medical Alley. Most are related to U.S. Food and Drug Administration (FDA) delays, the prospect of government user fees for medical devices, industry downsizing, product liability, and the unavailability of critical polymers used as biomaterials in medical implants (major biomaterials manufacturers are leaving the business in the wake of class action lawsuits against manufacturers of silicone breast implants and their suppliers). But health system reform is a key issue.

"It depends whether you want to paint the picture black or white," says Tom Meskan, Medical Alley president and executive director. Minnesota has between 400 and 600 medical-related institutions along geographic Medical Alley, which runs from Rochester through the Twin Cities to Duluth. Eighty percent of medical device manufacturers have fewer than 50 employees and are locked into day-to-day concerns about getting their products to market, Meskan says.

"State reform [the 1993 MinnesotaCare Act] has the potential to have significant impact on medical technology. There is a Health Technology Advisory Committee that will review specific procedures. Although the committee does not have regulatory power, it will have an impact on what technologies integrated service networks adopt [see related article, page 25]. This is part of the drive for information.

"It's no longer enough to demonstrate safety and efficacy," says Meskan. "Device manufacturers and people with new procedures are going to have to demonstrate cost-effectiveness, too."

Concerns about federal health care legislation, Meskan says, center around four questions: Will there be a National Health Board and, if so, what will be its makeup and powers? How will benefits be defined? Will there be price controls? And what will be the role of research?

"The No. 1 concern would be a National Health Board," Meskan says. "Is there going to be one? Most of the industry hopes the answer is no, but if there is one, how much will it allow for local flexibility on the particular products or procedures that might be covered?"

Price controls speak for themselves, he says. "The device industry tends to be pretty R&D intensive, and that could be problematic. If you restrict prices too much, where are you going to get the investment money to continue to advance your products?" Under a system of capitated payment, one of the features of managed care, clinics and laboratories are transformed from revenue centers into cost centers and are more impervious to traditional sales approaches. "It will have to be a different kind of sale. It will have to be better articulated to a greater number of people besides physicians—people such as materials managers, administrators, and committees that may include people from the business community," Meskan says, adding that demonstrating how a device saves money may determine its fate.

The effects of possible federal legislation on research funding is another serious concern to Medical Alley companies, Meskan says. Many of the ideas that lead to medical technology products have their origin in university research laboratories, and teaching hospitals are critically important for carrying out clinical research on

new technologies. Cost-containment measures that result in lower funding for basic and clinical research will have a direct impact on the ability of companies to develop new technology and bring products to market, he says.

Health system reform is already reducing the time available to physicians to conduct clinical research, which has been reform's major impact on academic health centers, says William Brody, M.D., provost for the University of Minnesota's Academic Health Center and former head of radiology at the Johns Hopkins School of Medicine. Brody, who is also a biomedical engineer and entrepreneur, says that physicians' time for such research used to be funded by an internal cross subsidy from patient care fees. "With reduction in reimbursement, clinical departments do not have the financial ability to underwrite faculty time for conducting research and teaching courses," he says.

Despite concerns about "the dark side" of health system reform, Meskan is optimistic. "We're lucky in Minnesota because there are a lot of people who understand the business," he says. "They have come out of the device industry and made some money and think they know how to continue to pursue that. They have a product idea and believe they can make it happen. I look upon that as seed corn. We've got an excellent device business infrastructure. This bodes well for the industry here, relative perhaps to device industries in other states."

To the extent that federal legislation is regulatory, small companies and venture companies will feel it first. "Government regulation in health care could and is affecting innovation by restricting new entries and start-ups," says Catherine "Kye" Anderson, chair, president, and chief executive officer of Medical Graphics Corp. in St. Paul, a leading innovator in cardiorespiratory diagnostic systems that employs 120 people. Large firms are better able to deal with government regulations because they can afford to do clinical trials overseas, Anderson says. According to the Health Industry Manufacturers Association, a growing number of firms are doing just that. U.S. medical technology firms invested nearly $1 billion overseas in 1992, three times the amount of the previous year.

Dr. Warren Warwick of the University of Minnesota invented a vest-like device to treat patients with cystic fibrosis, like young Sarah Moeschl, above. The vest helps patients cough mucus from their lungs and up into the trachea, enabling them to expel the mucus and reduce the threat of infection. Photo courtesy of the Minnesota Medical Foundation, U of M.

New Technology Can Reduce Costs, Too

Anderson believes medical technology can play a larger role in reducing costs and preventing disease. "We need to find ways through technology to reduce costs and keep people healthy. There's plenty of room in that arena," she says.

Funding agencies and foundations, which have helped to fuel the development and adoption of biomedical technologies, are taking the cue. Last year, the National Science Foundation and the Whitaker Foundation, the largest private funder of biomedical engineering research, launched a jointly funded research program, "Cost-Reducing Health Care Technologies." Grants are awarded to researchers working on "new or improved technologies that can reduce the cost of existing procedures or technologies in the de-

livery of health care." Applicants are required to provide a quantitative analysis of anticipated cost savings. One of the first funded projects was for development of a small, lower-cost magnetic resonance imaging (MRI) scanner. Conventional MRI machines can cost up to $3 million to buy and more than $1 million annually to operate.

Medical technology has gotten a "bad name" in the health system reform debate, says Peter Katona, Whitaker's vice president for biomedical engineering programs. "The main reason for the program is that we believe technology can help in reducing the costs of health care. This is extremely important for the future of technology in medicine." Katona says a similar research program involving the Whitaker Foundation and the National Institutes of Health will be announced soon.

Clinical trials of medical technologies are addressing cost-effectiveness issues as well as efficacy and safety. A multicenter clinical trial of 198 patients using an outpatient drug delivery device manufactured by SIMS Deltech, Inc., of St. Paul showed that hospital stays could be reduced by up to six days. Home-based intravenous antibiotic therapy via a computerized delivery system "is a highly cost-effective, well-tolerated approach to the management of infections, with efficacy comparable to hospital-based treatment," wrote Donald Poretz, M.D., in the introduction to a series of reports published in the August supplement of the *American Journal of Medicine*.

The studies were supported by a grant from the pharmaceutical manufacturer of the antibiotics. In William Brody's view, insurance companies also should support clinical research. "It seems to me that payers benefit from the cost-effective use of new technology and have a vested interest in preventing the introduction of technology that is not cost-effective," he says. "They should be willing to reimburse academic health centers to evaluate and test new technology. This needs to be done on a selective basis so that technology doesn't proliferate before it is adequately evaluated."

Health system reform, whether driven by market forces or legislation or both, will require greater scrutiny of costs in the development, manufacture, purchase, and use of medical technologies. The FDA is reported to be expediting device applications if they demonstrate cost savings, even though cost is not part of the agency's formal review. A set of guidelines is currently being developed by Medical Alley's Task Force on Cost Effectiveness, made up of representatives from device and pharmaceutical companies, the Business Health Care Action Group, integrated service networks, hospitals, physicians, academics, ethicists, and the state commissioner of health.

"We want to provide something practical and timely that will serve large health care systems—not only here in Minnesota, but around the country," says MMA President Andrew J.K. Smith, a Plymouth neurosurgeon and task force chair. There is "individual and collective excitement" about what can be accomplished, he says. The task force report will be finished in late winter or early spring.

At the Heart of the Debate

At the heart of the debate over the role of technology in medicine is the dilemma over what people want their society to be versus what they want available to them in time of personal need (see related article, page 25). No one has described the dilemma more compellingly than the late Lewis Thomas, the renowned physician-writer and philosopher of science.

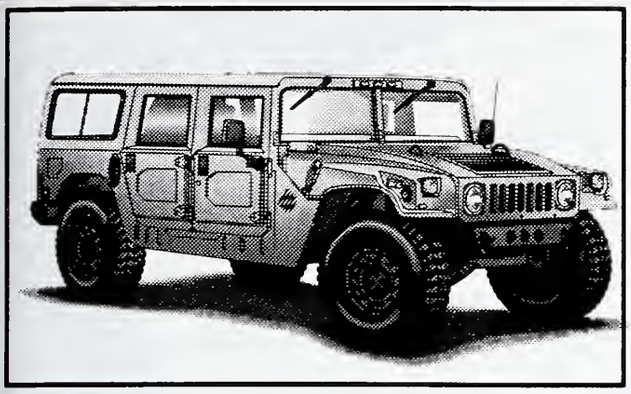
In the early 1950s, when Earl Bakken was building a business out of a garage in northeast Minneapolis and C. Walton Lillehei was leading the development of open-heart surgery, Thomas was right next door directing the pediatric research laboratories at the University of Minnesota Heart Hospital. Thirty years later, a pacemaker in his chest, Thomas said, "I am exceedingly pleased with my machine-tooled, obedient, responsive self. I would never have thought I had it in me, but now that I have it in me, ticking along soundlessly, flawlessly, I am subject to waves of pure vanity."

In a chapter entitled My Magical Metronome in his book "Late Night Thoughts on Listening to Mahler's Ninth Symphony," Thomas confessed that he wasn't really interested in how a pacemaker works. "As long as it works, and it does indeed, I prefer to be as mystified by it as I can be. ... I suppose I should be feeling guilty about this. In a way I do, for I have written and lectured in the past about medicine's excessive dependence on technology in general, and the resultant escalation in the cost of health care. I have been critical of what I have called 'halfway technologies,' designed to shore things up and keep flawed organs functioning beyond their appointed time. And here I am, enjoying precisely this sort of technology, eating my words." **MM**

William Hoffman is assistant to the director of the Biomedical Engineering Center at the University of Minnesota and a free-lance writer.

"It's Like Nothing I've Ever Driven"

— John Pendregast, M.D.



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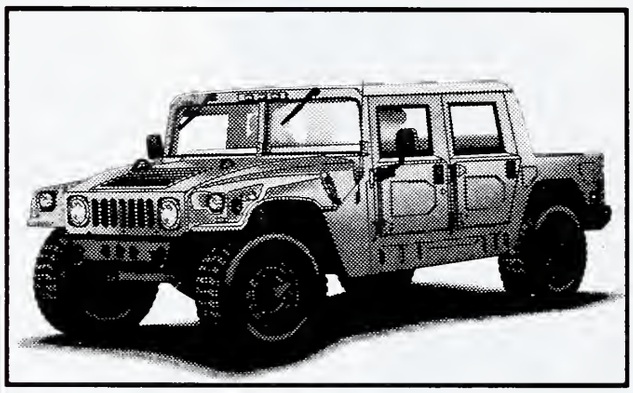

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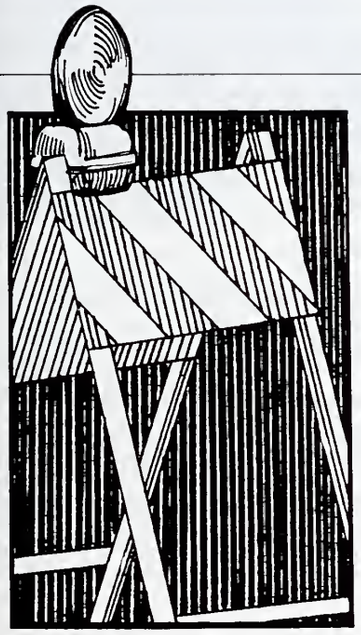

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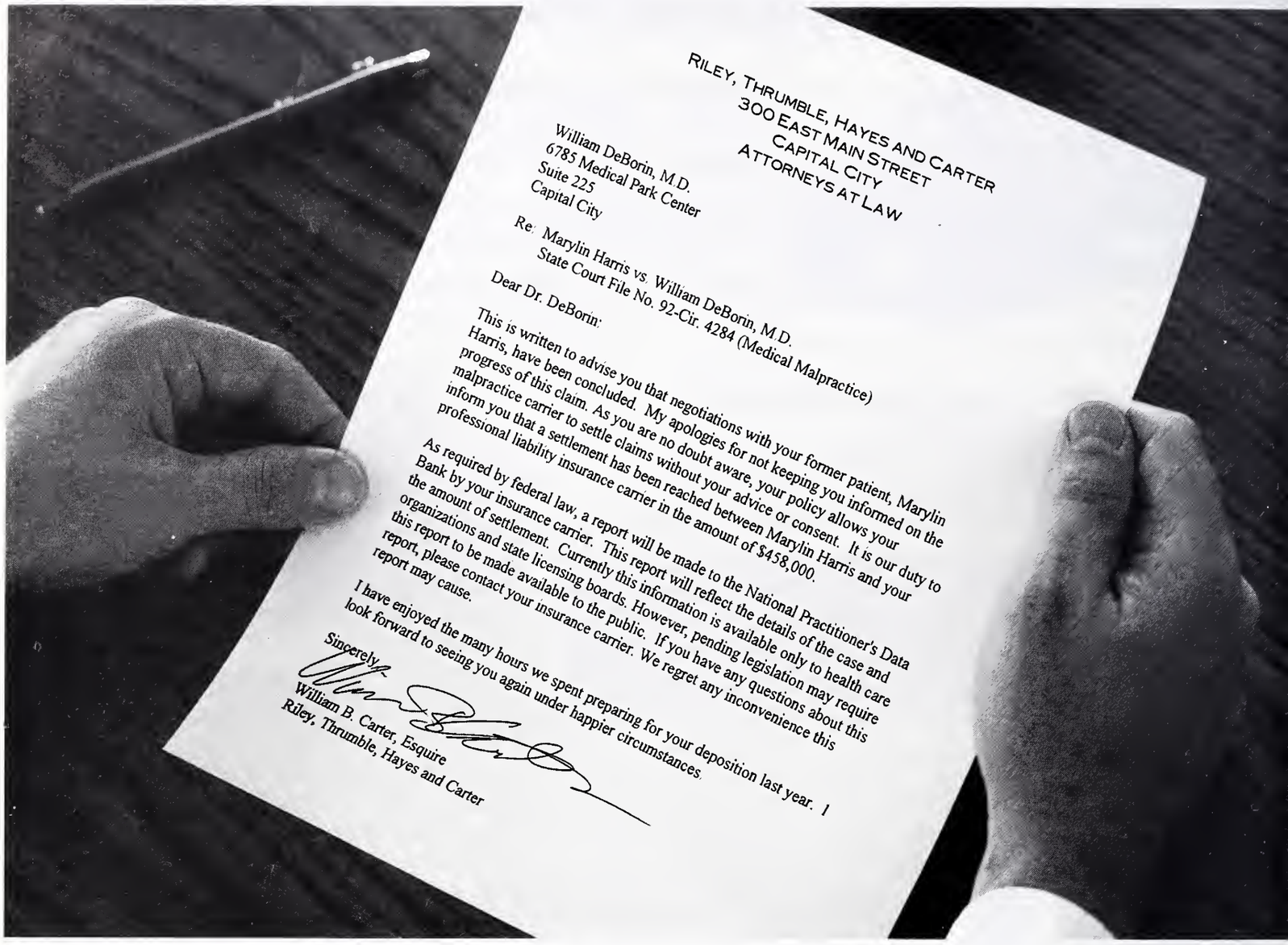

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Suite 225
Capital City

Re: Marylin Harris vs. William DeBorin, M.D.
State Court File No. 92-Cir. 4284 (Medical Malpractice)

Dear Dr. DeBorin:

This is written to advise you that negotiations with your former patient, Marylin Harris, have been concluded. My apologies for not keeping you informed on the progress of this claim. As you are no doubt aware, your policy allows your malpractice carrier to settle claims without your advice or consent. It is our duty to inform you that a settlement has been reached between Marylin Harris and your professional liability insurance carrier in the amount of $458,000.

As required by federal law, a report will be made to the National Practitioner's Data Bank by your insurance carrier. This report will reflect the details of the case and the amount of settlement. Currently this information is available only to health care organizations and state licensing boards. However, pending legislation may require this report to be made available to the public. If you have any questions about this report, please contact your insurance carrier. We regret any inconvenience this report may cause.

I have enjoyed the many hours we spent preparing for your deposition last year. I look forward to seeing you again under happier circumstances.

Sincerely,

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Minnesota Public Opinion on Health Care Resource Allocation

Steven Miles, M.D., and Robert Bendiksen, Ph.D.

ABSTRACT

Creating workable policies for allocating or rationing finite health care resources to meet the needs of individuals as well as the broader society vexes policymakers, providers, and consumers. This paper presents results of a March 1994 Lou Harris survey of 1,006 Minnesotans abaut health care allocation. Minnesotans believe that allocative or rationing decisions are inevitable and can be discussed. Individualized bedside allocative decisions are preferable to categorical or universal exclusions of some health care benefits. People want comprehensive health care and are willing to let sound clinical judgment, perhaps informed by practice guidelines, selectively withhold some services. The integrity of plan-based allocation or rationing may be best secured and safeguarded by standards that ensure that the decisions are based on patients' best interests, involve trusted clinical decision makers, and include lay participation in the decision making.

The question of how society will allocate its health care resources is one of the most morally difficult and politically volatile issues for health system reform. The huge number of potentially beneficial health care services far exceeds available societal resources. Biotechnology industries and medical research will continue to generate an increasing number of beneficial and costly health care technologies, which will add to the competition for finite resources. This paper describes results of an extensive March 1994 Lou Harris survey of 1,006 Minnesotans about health care allocation. The survey results suggest politically viable starting points for discussions on allocation and rationing policies.

Allocation and rationing are two ways of addressing the competition between finite resources and societal demands for health care services. "Allocation" means *assigning resources to selected services to meet prioritized needs*. For example, society allocates resources to prenatal care to address the problem of underweight babies. "Rationing," a term with more negative connotations in public debate, refers to *equitable means for limiting the deployment of resources*. For example, society might say that scarce donor livers will be given to persons on a queue, excluding persons with alcoholic liver failure. The question of how to design politically viable and medically credible policies for allocating or rationing health care resources to meet diverse public and individual health needs vexes policymakers, providers, and consumers. Many kinds of input will be brought to bear on this issue: technology assessment, legal scholarship, ethics debate, and research about the opinions of patients, insurance buyers, and the public.

Despite extensive research about public views on the health care system, surprisingly few public opinion surveys have examined beliefs about the allocation or rationing of health care. Such surveys could clarify how the public sees the difficult trade-offs between competing values, such as central budget control versus bedside judgment, or a patient's right to medical treatment versus responsible stewardship of shared (and limited) health care resources. Such surveys might elucidate the political feasibility of ideas that are part of Minnesota's health system reform discussion, such as practice guidelines that delimit the use of health care services. The following survey results offer such insights.

Methods

The Medica Foundation commissioned the Lou Harris Organization in March 1994 to survey Minnesotans about health care allocation. This survey was part of the foundation's Project Decide program, a multifaceted effort to address ethical issues in health care resource allocation and end-of-life care. Lou Harris polled 1,006 randomly selected Minnesotans using a 60-item phone survey, professional interviewers, and a detailed set of questions pertaining to values and preferences for health care resource use. The sampling error is +/- 3%.

The demographic characteristics of the adult respondents (see Table 1), with the exception of the small number of racial and ethnic minorities,* is typical of the United States as a whole.†

Results

The data we selected from the 127 tables of responses generated by this survey highlight opinions supported

by more than 65% of respondents, a level of support that marks the most immediately viable directions for policymaking. The major findings are summarized in terms of public opinion on reconciling these dilemmas:

1. the moral ideal of helping people vs. the constraints created by finite medical resources;
2. the moral ideal of equality vs. wide differences in personal wealth;
3. clinical judgment vs. patients' personal choice;
4. institutional rationing/allocation policymaking vs. patient-centered decision making.

Table 2 gives examples of survey items and responses that cover these issues.

Health care idealism and finite medical resources

Respondents gave conflicting responses to questions regarding insurers' ethical obligation to cover health care and their financial ability to meet every need. Younger Minnesotans have an especially strong moral view of the duty to provide health care: two-thirds of persons under age 36 say that health insurance should pay for any million-dollar treatment that will save a life. Fewer than half of persons over age 48 affirm such a moral view. On this issue, age is a better predictor of point of view than political philosophy.

Such idealism notwithstanding, two-thirds of Minnesotans agree that with so many new, expensive treatments, no insurance company could pay for all medical care. A similar number say that insurers are making choices to disallow coverage every day. Furthermore, nearly three-fourths of Minnesotans believe that rationing services will be inevitable within 10 years. Although a majority of all demographic groups in Minnesota, except racial and ethnic minorities, hold this view on the inevitability of rationing, the view is not as prevalent among persons with less education.

Policymakers must seek a way to reconcile the public's belief in a moral duty to provide care with the finite resources available to meet those needs. The survey suggests that education and pragmatism are potential tools for solving this dilemma. Minnesotans were asked at the beginning and end of this lengthy survey if it is ever reasonable for an insurer to decide not to meet a health care need. Initially, Minnesotans rejected such a decision by 49% to 41%. At the end of the survey, after contemplating these issues, respondents accepted the reasonableness of such choices by 60% to 37%. This change was greatest among well-educated and conservative persons, but it occurred in all groups.

Equal health care needs and unequal abilities to pay

Fairness in health care allocation or rationing may be defined as meeting comparable needs with comparable adequacy. Minnesotans endorse an egalitarian vision of ideal access to health care by overwhelmingly supporting the view that "everybody should have the right to get the best possible health care, as good as a millionaire gets."

This view, however, is tempered by a recognition of and even support for differing abilities to pay for health care and insurance. More than four of five Minnesotans say that some people will inevitably get more and better health care than others. Furthermore, in a consensus that stretches across the political spectrum and is only slightly weaker among people who are less well off, more than three-fourths of Minnesotans agree that individuals should be able to choose to purchase more expensive and, thus, more extensive health plans. The most striking acceptance of financial inequality in health care

Table 1

Demographic characteristics of respondents

Women	52%	
Men	48%	
Age		
	18-24	11%
	25-34	24%
	35-44	22%
	45-64	27%
	65+	16%
Education		
	Less than high school	10%
	High school graduates	42%
	Some college	28%
	College graduates	14%
	Post-graduate	7%
Religion		
	Very religious	30%
	Somewhat religious	57%
	Not religious	12%
Income		
	$7,500 or less	6%
	$7,501-$15,000	9%
	$15,001-$25,000	19%
	$25,001-$35,000	21%
	$35,001-$50,000	19%
	$50,001-$75,000	14%
	Over $75,000	8%
Race		
	White	94%
	African-American	2%
	Hispanic-American	2%
	Asian-American	2%
Political Orientation (self-described)		
	Conservative	32%
	Middle-of-the-road	48%
	Liberal	20%

*The small number of respondents representing racial and ethnic minorities in this survey do not permit analysis of the striking and important findings in these communities.

†Men are somewhat more likely to say they are conservative than women (38% vs. 28%). Women are accordingly more likely than men to describe themselves as middle-of-the-road (50% vs. 44%). Minnesotans over 65 years old are slightly more likely than the average nationally to say they are conservative (37% vs. 33%); young adults are just slightly more likely to describe themselves as liberal (18% vs. 16%). Education does not have a major impact on political philosophy in Minnesota, although college graduates and postgraduates are slightly more likely to be liberal. Conservative Minnesotans are more likely to describe themselves as very religious (47%) than those who say they are politically "middle-of-the-road" (38%) or those who are politically liberal (9%), a relationship that resembles national findings.

Table 2

Selected responses

Idealism and finite societal resources

	Agree	Disagree	No answer/ Don't know
Insurance should pay for any treatment that will save a human life, even if it costs a million dollars to save one life.	58	38	5
There are so many new, expensive treatments, surgical procedures, transplants, and medical devices that it is impossible for any insurance plan to pay for all of them.	63	34	3
Ten years from now there will be so many new and very expensive ways of treating sick people that all insurance plans will have to make tough choices about what they will or will not pay for.	72	25	3

	Reasonable	Unreasonable	Depends	No answer/ Don't know
Pre-test: All health plans cover the cost of some treatments and not some others. Do you feel this is reasonable or unreasonable?	41	49	6	4
Post-test: All health plans cover the cost of some treatments and not some others. Do you feel this is reasonable or unreasonable?	60	37	NA	2

Equal health care needs and unequal abilities to pay for health care

	Agree	Disagree	No answer/ Don't know
Everybody should have the right to get the best possible health care, as good as the treatment a millionaire gets.	85	14	1
Whatever system we have, some people will always get more and better health care than others.	84	15	1
Where possible, people should have a choice between health plans that are more expensive and cover more treatments, and plans that are less expensive and cover less.	78	19	2

	Very/ somewhat acceptable	Not very/ not acceptable	No answer/ Don't know
How acceptable do you think it would be for a health plan to require patients who receive very expensive treatments to pay 5% of the total costs, so that they would pay $5,000 for a heart transplant costing $100,000?	81	17	2

Clinical judgment and personal choice

	Should	Should not	No answer/ Don't know
If a patient with a headache insists on a very expensive test to see if he has a brain tumor even though his doctor says the test is not necessary, should the insurance pay for this?	32	65	4
It a patient with a heart condition insists he wants to have bypass surgery costing $30,000 when his doctor says that all he needs is the regular use of certain drugs, should insurance pay for the surgery?	20	76	4
When a patient is very ill and his doctor says he has no hope of recovery, do you think that the patient's family should have the right to demand that he be kept alive by a very expensive life-support system?	31	65	4

allocation is the support for large copayments, e.g., a $5,000 copayment for a $100,000 heart transplant. This support spans the political spectrum and range of respondent incomes. The reason for this broad support of large copayments, which could impose a barrier to essential life-saving services, was not surveyed. Perhaps the $5,000 copayment is viewed as removing the welfare stigma of free care; perhaps it is not seen as a significant barrier to obtaining such care; or perhaps it is incorrectly viewed as a substantial subsidy for financing such operations.

Clinical judgment and personal choice

Minnesotans believe it is acceptable for an insurer to refuse to pay for a service that a physician says is inappropriate, even though a patient wants the service. Two-thirds of respondents say patients should be denied payment for non-medically indicated CT-scans, such as when they want the scan to rule out a brain tumor as a cause of headaches. Three-fourths of respondents are willing to be directed to medical management rather than preferred surgical management for heart conditions. Persons who are less well-off or less well-educated are largely willing to accept such constraints, but they are less comfortable with this proposal.

This high level of support, however, may not constitute a mandate for medical judgment in dramatic "futility" scenarios, in which doctors conclude there is no hope of recovery and the family demands continued expensive life support. A third of Minnesotans believe that the family's preference in such situations should be honored, apparently asserting that the ultimate control of life-and-death decisions should be under patient and family control rather than medical authority. Unfortunately, the survey did not ask whether insurers should continue to pay for treatment under such circumstances.

Institutional policymaking and patient-centered decision making

The question of who makes rationing or allocation policy is as important as what is decided. Even reasonable allocative decisions are less likely to be clinically or politically palatable if the process behind them is not trusted. Such decisions may be made as a general policy about insurance benefits or in the course of resolving individual clinical disputes. At both levels, Minnesotans strongly believe that the rationing/allocation decision-making processes must be based on medically sound and empathic judgment.

For example, in response to the question, "Which one of these do you think should have the biggest say on what procedures should or should not be covered?" respondents chose a committee of health plan members (35%), doctors (33%), or committees of distinguished community leaders (17%) over the federal government (4%) or insurance company (2%).

Minnesotans say that if the patient and the doctor cannot agree on what treatment is appropriate, a special committee of doctors and lay people (59%) is the preferred way to make a final decision, followed by deferring to the patient (19%), the doctor (17%), or the hospital (7%), any of which is strongly preferred to decision making by the third-party payer (1%).

In coming to general decisions about what services insurance should cover, Minnesotans say that health care has diverse goals, including: 1) preventing many people from getting life-threatening diseases; 2) helping many people; 3) helping young and middle-aged people, as well as the elderly; 4) greatly improving quality of life; 5) adding many extra years of life, not just a year or two; 6) saving lives; and 7) enabling disabled people to live more normal lives. No one of these goals is so overwhelmingly supported so as to serve as a basis for creating an allocative priority for one type of health care over another.

Discussion

MinnesotaCare, the state's nationally watched managed care model of health system reform, explores several types of allocative policies. Under MinnesotaCare, the Legislature has proposed to define a global budget for universal health care and to enforce the budget on comprehensive health care networks. The Legislature is attempting to define a mandated, universal package of comprehensive health care benefits, incorporating elements of the Minnesota Medical Association's definition of essential health services (see page 46). It increased legal protection for providers who follow practice guidelines. It has proposed to use copayments to decrease demands for health services—elective use of emergency rooms, for example—and to ban all financial barriers to highly valued services, such as prenatal care. It promotes technology assessment (see related article, page 25) and outcomes-based health services research, ideally to guide patients and physicians in choosing more effective health care. Oregon's attempt to prioritize and ration its health care services was subject to intense national scrutiny (see page 30); Minnesota progress will also have a national audience.

The kind of survey we describe here has several implications. Public opinion surveys can identify politically viable starting points for discussion of ideas about the development of allocative or rationing policies. Although they do not predict the ultimate political success of a policy proposal, they do shed some light on how controversial problems or solutions should be put on the table for serious public policy consideration. They can identify needs for education or strategies for constructive or special-interest efforts to sway public opinion. They can illuminate the values of a society, even though public opinion should not be equated with what might be an ethical or desirable path. In fact, the widely supported ideas elicited by this survey may represent ethically problematic or dangerous directions that public policy may be inclined to experiment with.

We believe this survey says the following things about Minnesotans:

- Minnesotans believe that allocative or rationing decisions are inevitable and can be discussed, albeit reluctantly.
- Minnesotans find individual-

ized bedside allocative decisions preferable to categorical or universal exclusions of some health care benefits. People want comprehensive health care and are willing to let sound clinical judgment, perhaps aided by practice guidelines, selectively withhold some services.

• Public support of plan-based allocation or rationing may be best secured and safeguarded through standards that ensure the decisions are based on patients' best interests, involve trusted clinical decision makers, and include lay participation in decision making. The findings also suggest that such processes must be clearly communicated to health plan members, with particular attention paid to people with lower incomes and people from minority groups, who are highly skeptical of plans' motives on such matters. The survey results suggest that bold discussion is needed about new ways to engage broad-based participation in coverage decisions and new ways to seek public and consumer consent to insurance allocation and rationing decisions.

Policy leaders on these issues should focus on pragmatic education that affirms and balances the moral duty to provide care with the concept of limited resources. The survey results show that policymaking in this difficult area requires trust among all parties, a respect for lay and personal views on these decisions, and a sense of the widely held belief in society's moral duty to provide care, circumscribed by an awareness of limited resources. Policy leaders grappling with this issue should not dismiss as idealist or naive the belief in a moral duty to provide health care to all. Interest groups adversely affected by a proposed allocation policy could attempt to derail such efforts by appealing to Minnesotans' moral idealism on this matter. This survey suggests that political approaches to these issues can be bipartisan, since no clear correlation exists between political philosophies and views on these issues. Minnesotans appear ready to discuss publicly the allocation of health care resources. Though necessary, it promises to be an uncomfortable discussion. MM

Acknowledgments

The authors gratefully acknowledge support received from the Medica Foundation and from the Health of the Public Program sponsored by the Pew Foundation and the Robert Wood Johnson Foundation.

A copy of the complete survey results may be obtained by sending $15 to the Center for Biomedical Ethics, 2221 University Avenue SE, Suite 110, Minneapolis, MN 55414.

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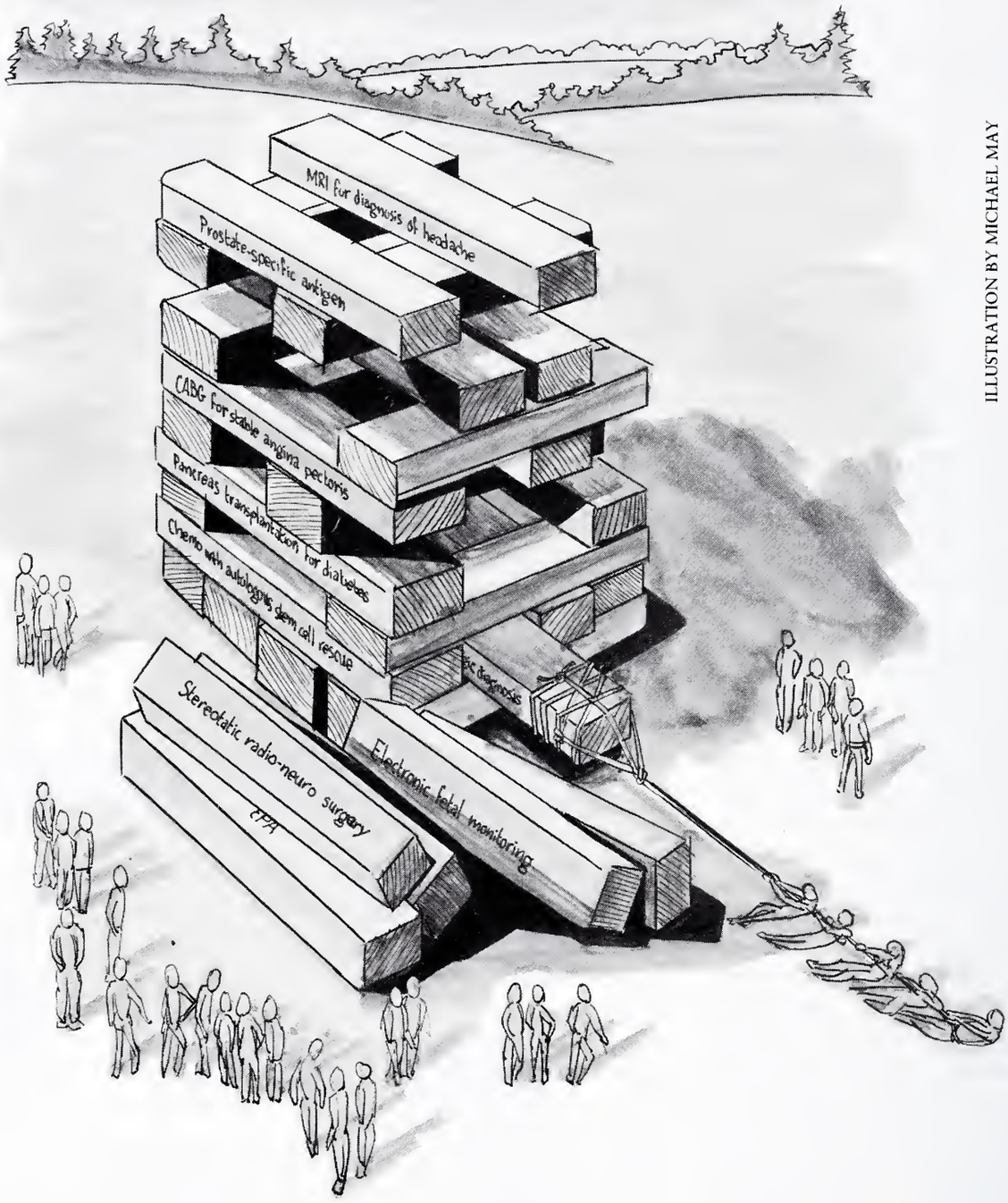

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RESOURCE ALLOCATION

Using Technology Appropriately

Challenges for Minnesota's Health Technology Advisory Committee

Reinhard Priester, J.D.

The MinnesotaCare Acts of 1992, 1993, and 1994 establish the framework for meaningful health system reform in Minnesota. Combined, they target the three interrelated problems of spiraling costs, inadequate access, and concerns about quality. The avowed, overarching goal is to assure quality, affordable, and accessible health care to all Minnesotans. A central concern is the conflict raised by rapidly escalating health care costs (due in large measure to new and more intensive use of existing technologies) and the simultaneous introduction of growth limits on total health care spending in the state. These two developments underscore the finite nature of health care resources and the resultant inability to provide all health services to all who could benefit. The challenge is to allocate our limited resources more appropriately.

As part of the overall effort to reduce health care spending, the Legislature established the Health Technology Advisory Committee (HTAC) to conduct evaluations of health care technologies. This essay critically examines the role of HTAC, one of only two state-level, public policy bodies of its kind,* in promoting the more appropriate use of technologies within the context of limited resources.

Background

Health care resources are limited; they are scarce relative to needs. No society can afford to provide every service of potential benefit to everyone in need. This scarcity will be reinforced by Minnesota's proposed growth limits on health care spending. Under the state's system of global limits on growth, total private and public health care spending in Minnesota will not be allowed to increase at a rate higher than state-imposed limits. These growth limits will also be applied to specific components of the state's health care system, including Medicaid, MinnesotaCare, the state's new integrated service networks, and the regulated all-payer option (RAPO is a fee-for-service option for physicians who choose not to participate in ISNs). In other words, the state will limit the financial resources available to provide health care services for every public and private health plan and program, as well as for the system overall.

Thus, we cannot now (and will be increasingly unable to) provide everything that might have benefit; instead, we must choose among competing health needs and make difficult trade-offs. When resources are limited, some patients, somewhere, will necessarily be denied beneficial care, and the denial will be for reasons of cost, not because the beneficial care doesn't exist.

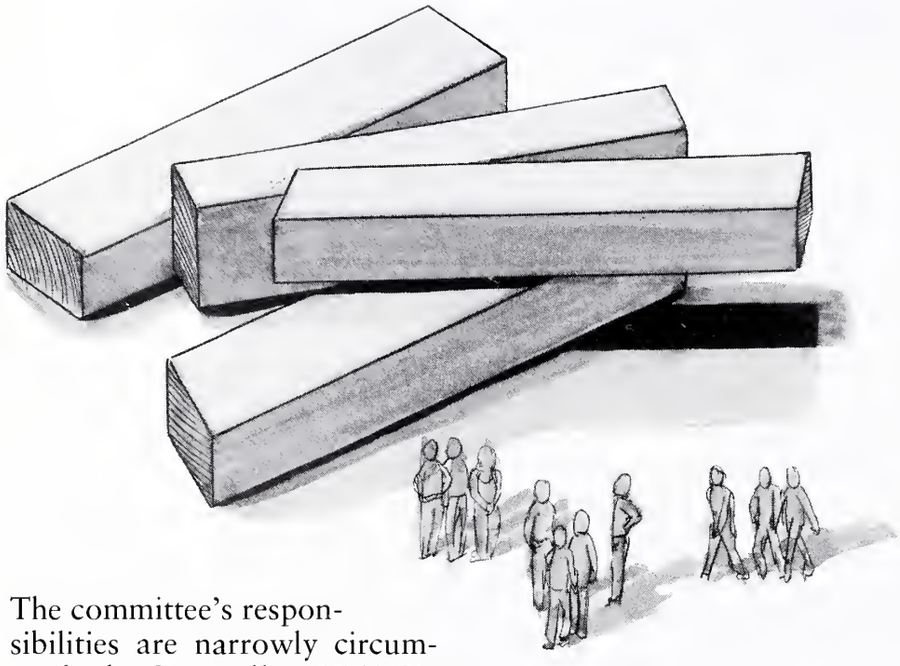
Resource Allocation and Technology

Health care technology contributes substantially to patient health and well-being—and to escalating costs. Informed decisions regarding the use of such technology are, therefore, critical for improving resource allocation, that is, for making appropriate trade-offs and for choosing among alternative uses of limited resources. Technology assessment—a strategy for systematically examining the safety, effectiveness, and cost-effectiveness of emerging and existing technologies—is a tool for developing essential information for such decisions.

Although numerous federal agencies and private organizations support or conduct medical technology assessments, neither Minnesota nor the United States has a coherent system for assessing all health care technologies. Except for drugs and some medical devices, for which the FDA is responsible, many technologies are not rigorously assessed before their widespread use. Moreover, existing assessment activities concentrate on new technologies—not on those that are widely accepted and possibly outmoded; thus, many expensive older technologies with questionable outcomes remain uncritically reimbursed.

The MinnesotaCare Act of 1992 created the Health Technology Advisory Committee, a subcommittee of the Minnesota Health Care Commission, to conduct evaluations[1,†] of health care technologies.[2,‡] HTAC is charged with developing information to promote the appropriate and cost-effective use of new and existing technologies.

*The only other similar state-level group is the Oregon Health Resources Commission.



The committee's responsibilities are narrowly circumscribed. Generally, HTAC's work, including its findings and recommendations regarding specific technologies, will be made available for others to use (or not use) at their discretion. HTAC has no regulatory powers; instead, its technology evaluations may be used by health plans, employers, government programs, and others to make informed decisions about developing, acquiring, using, and paying for technologies.

Time, staff, and other limitations will not permit HTAC to evaluate all technologies; accordingly, HTAC has developed a process for designating technologies for evaluation. First on HTAC's list was the thrombolytic t-PA for acute myocardial infarction. Subsequent technology evaluations will similarly address specific uses in particular circumstances.

In conducting technology evaluations, HTAC must consider "safety, improvement in health outcomes, the degree to which a technology is clinically effective and cost-effective, and other factors." The most controversial criterion, "cost-effectiveness," is defined in the 1992 MinnesotaCare Act to mean that "the economic costs of using a particular technology to achieve improvement in a patient's health outcome are justified given a comparison to both the economic costs and the improvement in patient health outcome resulting from the use of alternative technologies."[3] This criterion directly targets the costworthiness of specific health care technologies: it asks, "Are the benefits of the technology worth the cost?"

Two Perspectives

There are two fundamentally different perspectives for making resource allocation decisions and for determining when the benefits of a particular technology are worth the cost: the population perspective and the individual perspective. Decisions made from the population perspective seek to maximize care for a population, e.g., a group of patients or a community. The goal is to allocate resources as efficiently as possible for a population. This is the traditional public health perspective, guided by the utilitarian principle of achieving the greatest good for the greatest number. In contrast, decisions made from the individual perspective seek to maximize care for the individual patient. These two perspectives conflict—especially when health care resources are limited. As author David Eddy explains, "to the extent that maximizing care of individual patients either restricts resources available for other activities for other people or drives up costs that other people will have to pay, there is indeed a conflict between the individual and society."[4]

To further clarify this distinction, Eddy notes that individuals may shift perspectives depending on whether they are healthy or ill. Individuals adhere to the population perspective when they are healthy and are deciding whether to buy health insurance. They tend to follow the individual perspective when they already have a condition or disease, for example, a heart attack, and are in need of treatment. Maximizing care for individual patients attempts to do what is best for individuals when they are sick. Maximizing care for a population is best for those who are healthy.

To illustrate the conflict between the individual and population perspectives, consider HTAC's first technology evaluation report.[5] Three of the report's "conclusions" are relevant here:

- Based on a $2,000 difference between the cost of the thrombolytics t-PA and streptokinase, using t-PA

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†As used here, "evaluations" are critical reviews of existing technology assessments conducted by other entities. Assessments (that is, the direct examination of a technology's safety, effectiveness, and other factors) are technically difficult, costly, and time consuming. HTAC is not explicitly authorized to perform such assessments itself.

‡The MinnesotaCare Act of 1992 defines "technology" broadly to include "high-cost drugs, devices, procedures, or processes applied to human health care, such as high-cost transplants and expensive scanners and imagers."

would reduce mortality at a cost of approximately $200,000 per additional life saved or approximately $29,000 per life year saved (based on an incremental life expectancy of 11 years);

• On the basis of the data currently available, it is estimated that using t-PA as the thrombolytic of choice in Minnesota would save approximately 35 more lives annually, when compared with streptokinase, at an additional total cost of approximately $7 million; and

• Physicians should recognize that the cost of t-PA is approximately seven times that of streptokinase, and hence, the use of t-PA should be confined to patients who, *in the treating physician's judgment*, are most likely to benefit (emphasis added).

The implicit question behind these conclusions is as follows: Assume patient A has just had a heart attack. The patient's chance of dying if streptokinase is used is 7.3 percent. This could be reduced to 6.3 percent if t-PA is used instead. The incremental cost of t-PA is $2,000. Is the reduction in the risk of mortality worth this additional expenditure?

Clearly, the report's conclusions come from the individual perspective. The focus is on patients who have suffered an acute myocardial infarction and, thus, need treatment. The evaluation compares the use of one thrombolytic (t-PA) with use of another (streptokinase) by assessing the relative costs and benefits. The evaluation does not consider how the projected $7 million could be allocated to people who have not suffered an acute myocardial infarction. It does not consider other highly effective uses for which these resources could be used, for vaccinations, as an example. Note also that HTAC's question is directed to the treating physician.

Is HTAC adopting the right perspective?

The purpose of HTAC is to develop information about health care technologies that can lead to the appropriate and cost-effective use of limited health care resources. The overall objective—based on Minnesota's health reform initiative—is to provide the most affordable and high-quality health care to the entire population. Should HTAC, then, evaluate and make recommendations about a specific health care technology by asking what is best for an individual patient, or by asking what is best for an entire population, such as all Minnesotans?[§] Two lines of reasoning suggest that the more relevant question is the latter, based on the population perspective.

First, the MinnesotaCare Act of 1993 appears to adopt the population perspective. The act specifies that HTAC's evaluations may be used by the following:

• ISNs, employers and other group purchasers, government programs, and regulators of the RAPO in making decisions about coverage, contracting, purchasing, and reimbursement;

• the commissioner of health and other organizations in the development of practice parameters;

• health care providers in making decisions about adding or replacing technology and the appropriate use of technology; and

• consumers in making decisions about treatment.[6,¶]

Technologies HTAC Is Evaluating

Technologies selected for evaluation by HTAC in the coming year in the order in which they will be evaluated:

- Prostate-specific antigen (PSA) for prostate cancer screening;
- Stereotactic radio-neuro surgery for brain tumors;
- Magnetic resonance imaging (MRI) for diagnosis of headache;
- Electronic fetal monitoring during labor;
- High-dose chemotherapy with autologous stem cell rescue for breast cancer; and
- Pancreas transplantation for patients with diabetes.

HTAC is seeking comments and information relating to the evaluation of these health care technologies. To keep physicians and other interested parties apprised of HTAC's evaluations, mailing lists are being compiled for each technology evaluation project. Individuals on the mailing lists will receive meeting notices and draft materials for review. To be placed on the mailing lists, call HTAC at 612/282-6337.

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§At several recent meetings, the HTAC has broached the conflict between the individual and population perspectives. However, an in-depth discussion of these two perspectives and the possible articulation by HTAC of the appropriate perspective for its recommendations are agenda items for a future HTAC meeting.

¶Three other potential uses are not relevant to this discussion: "by the commissioner in retrospective and prospective review of major expenditures; by medical device manufacturers in developing and marketing new technologies; and as otherwise needed by health care providers, health care plans, consumers, and purchasers."

The first three potential uses call for administrative decisions, such as designing benefits plans, purchasing technologies, and developing practice parameters. These decisions adopt the population perspective; they are made in the boardroom, not at the patient's bedside. Here, the primary task of HTAC is to provide information to ISNs, the state, and others to help them make decisions about health care technology that maximize the extent and quality of care for a group. The appropriate perspective for the fourth potential use, which targets consumers, is not clear. Consumers adopt the population perspective if they use HTAC's evaluations to make health insurance purchasing decisions. Only if consumers use the evaluations to decide on care when they are sick (when they are, in fact, *patients*, not consumers) is the individual perspective appropriate. Eddy presents a second, more compelling, line of reasoning supporting the population perspective: "By any aggregate measure of health care quality, such as morbidity rates, mortality rates, life expectancy, measures of health status, or quality-adjusted life-years, and for any specified level of resources, choices made from the [population perspective] can always provide as high a quality of care as choices made from the [individual perspective] and can often provide a higher quality of care."[7] This means that if allocation decisions are systematically made from the population perspective, more people will live longer, higher quality lives, at a lower cost than if such decisions were made from the individual perspective. Resource allocation decisions made from the population perspective are more likely to advance the professed overall goal of Minnesota's health reform initiative. The relevant question for HTAC's evaluation of t-PA, therefore, is not whether a patient who has suffered an acute myocardial infarction should be treated with t-PA; it is whether healthy people would want to purchase coverage for t-PA "to provide for the unlikely event that any one of them were to fall ill."[8]

Is HTAC asking the right decision maker?

HTAC's evaluation report concludes that the "treating physician" should ultimately decide whether using t-PA is appropriate. The treating physician may be the right decision maker if the individual perspective is adopted to make this decision. However, the treating physician clearly is not the right decision maker if the population perspective is adopted, since the physician would then be required to assume responsibilities that are in direct conflict with the traditional obligation to each patient.

Traditional advocacy: The physician's traditional role in the physician-patient relationship is to be the patient's advocate. When practicing medicine, it is often said, physicians cannot serve two masters. They must be dedicated to serving the patient's interests. This requires effacing their self-interests and, more importantly, placing the patient's interests above all others, including those of other patients and society. Author Norman Levinsky forcefully advanced this view of patient advocacy when he wrote that "physicians are required to do everything that they believe may benefit each patient without regard to costs or other societal considerations. In caring for an individual patient, the doctor must act solely as the patient's advocate against the apparent interests of society as a whole, if necessary."[9] In sum, with traditional advocacy, treatment decisions are made from the individual perspective.

This concept of the advocacy role is appropriate only if two conditions are met: 1) everyone has a physician advocate, and 2) resources are limitless. Neither condition is met today. Clearly, many people (primarily the uninsured) do not have an advocate. And health care resources are limited for the health care system generally, as well as for individual health plans. Requiring physicians to do everything of medical benefit for their patients, to make treatment decisions as if resources were limitless, leads to irrational allocation of resources.

Modified advocacy: An alternative concept of advocacy is needed to resolve the conflict physicians face when resource allocation decisions are made from a population perspective. This alternative concept explicitly recognizes scarcity, pointing out that treatment choices for an individual patient will affect the resources available for others and that money used to care for one patient means money not spent to care for another—who may, in fact, benefit more. The concern is not limited to the care of a particular patient, but also considers the patient's needs in relationship to the needs of others and in light of available resources. From the modified advocacy perspective, physicians have obligations not only to their patients, but also to others; they must recognize that "behind each presenting patient awaits another patient in need of services."[10] This clearly conflicts with the traditional view since, operating from this perspective, physicians may do less than the maximum for some patients in order to conserve resources for the greater benefit of other patients. They are under a duty to promote the welfare of the broader population, and this duty sometimes overrides their responsibility to promote the interests of specific patients.

How can physicians balance the interests of a population with the interests of their patients? Although physicians should incorporate the interests of others,

they should not be required to balance interests at the bedside. Instead, they should only be required to adhere to previously established constraints, such as a managed care organization's practice guidelines for appropriate care or a third-party payer's coverage limitations. These constraints, or resource allocation rules (appropriately informed by HTAC's recommendations), are made from a population perspective at an administrative level; that is, they are developed in the boardroom.

Because physicians have the requisite knowledge about what works in medicine and the relative harms and benefits of alternative interventions, they should be involved in establishing such allocation rules. However, they should be involved as health care administrators, managers, and members of professional organizations—not in their capacity as "treating physicians" or bedside clinicians. While physicians should help develop allocation rules, they must then play by the rules. And within those rules, they should continue to aggressively advocate for their individual patients' interests. If they believe the rules are detrimental to their patients, they should work to change them.[11]

Conclusion

As Minnesota moves forward with health system reform, decisions about allocating limited health care resources will become more pressing. The Health Technology Advisory Committee has been established to make recommendations for the appropriate use of technologies. To advance the overall goals of Minnesota's reform efforts, HTAC should adopt the population, rather than the individual, perspective; its recommendations should seek to maximize care for a group, not just for individual patients. HTAC's recommendations should also honor physicians' patient advocacy role. However, in an era of limited health care resources, this role should be modified to require physicians to aggressively advocate for individual patient's interests within established, recognized resource allocation rules. Although physicians should participate in establishing such rules, they should not do so at the bedside as *treating* physicians. MM

Reinhard Priester is an independent health policy consultant in Minneapolis. He was formerly a research associate at the University of Minnesota Center for Biomedical Ethics. He is the bioethics representative on the Health Technology Advisory Committee (HTAC).

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The Oregon Health Plan

The highly publicized Oregon Health Plan is a program that includes universal access provisions through managed care, practice guidelines, insurance reform, and the controversial prioritized list of services for the state's Medicaid program. Oregon ventured into health system reform partially as a result of the state's 1987 decision to eliminate Medicaid funding for certain transplant procedures. Shortly after the policy was implemented, a 7-year-old boy died from leukemia after being denied coverage for a bone marrow transplant. The resultant public attention to Oregon's Medicaid policies led the state to attempt to distribute resources more fairly.

Oregon's ambitious plan attempts to provide coverage for all the state's residents currently without health insurance. Its complex plan is designed to increase access to health care for the uninsured through Medicaid by limiting the types of services covered. Certain medically necessary services are excluded if the outcome does not justify the effort or the costs as determined through a complex ranking process.[1]

The Oregon Health Services Commission (OHSC), an 11-member group that included four primary care physicians, was created to assist in the prioritization of health services.[2] Using a list of 696 condition/treatment pairs, the OHSC ranked the services through a process that included widespread involvement of the state's citizens through surveys, public hearings, and town meetings. The value preferences gleaned from this process were combined with determinations of net health benefits (medical effectiveness). The list of 696 condition/treatment pairs was delivered to the Legislature, which had the task of drawing the line at the point that would define which services would be covered. Currently, any service ranked below number 565 on the list is not covered.[2]

Table

*The five top and bottom treatment pairs in the OHP**

Ranking	Diagnosis	Treatment
Top Five: Covered		
1	Severe/moderate head injury: hematoma/edema with loss of consciousness	Medical and surgical treatment
2	Insulin-dependent diabetes mellitus	Medical therapy
3	Peritonitis	Medical and surgical treatment
4	Acute glomerulonephritis: with lesion of rapidly progressive glomerulonephritis	Medical therapy including dialysis
5	Pneumothorax and hemothorax	Tube thoracostomy/thoracotomy, medical therapy
Bottom Five: Not Covered		
692	Lymphedema	Medical therapy, other operation
693	Other aplastic anemias	Medical therapy
694	Tubal dysfunction/other causes of infertility	In-vitro fertilization, GIFT
695	Hepatorenal syndrome	Medical therapy
696	Spastic dysphonia	Medical therapy

*Azevedo D. America from de facto to explicit? Med Econ 1993;70(10):184-99.

KITZHABER

(continued from page 7)

health care." This goal, coupled with a set of principles to guide the deliberations of the coalition, enabled the group to come up with an innovative approach to health system reform. That meant creating legislation that would ultimately provide universal access to health care for Oregonians while still balancing expenditures for health care with other social investments that affect health. To do so, the coalition established a process for prioritizing health care services based on their health benefit as determined by clinical effectiveness and public values. They then linked the priority list to the state budget process so that the final benefits package would be determined as part of the same debate that dealt with housing policy, substance abuse prevention, and education.

Support from organized medicine was crucial to the passage and implementation of OHP. Many observers credit Kitzhaber's persuasive powers with garnering support. As one long-time capitol staffer put it, "There is no question that Kitzhaber's ability to speak to doctors in their native tongue was a great boost to passing the health plan."

Kitzhaber himself is more modest. "The Oregon medical community is really a good group. They realize there are problems in the system and that they have a unique and valuable perspective to offer in fixing those problems," he says. "They also realize that it is in their long-term interest to be known as a force for positive

The Oregon plan has received considerable attention and criticism. The Bush administration denied Oregon's request for a waiver to implement the plan on the grounds that it was discriminatory against people with disabilities. Other criticisms have focused on the methodology used in ranking services and on the implications of the plan for the rationing of health care services for the poor.[3] Nevertheless, the Clinton administration, in March 1993, approved Oregon's revised request for a waiver with certain adjustments to the prioritization list to ensure that there is no discrimination against disabled persons. The accompanying table displays the top five treatment pairs found in the Oregon Health Plan, as well as the bottom five treatment pairs for which coverage is not provided. Despite the controversy, Oregon's initiative has generated renewed interest in benefit design and resource allocation decisions.

–By Janet Silversmith

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change rather than as a privileged and self-serving interest group."

But his past accomplishments are history. As the gubernatorial campaign moves forward, Kitzhaber can spare little time for reminiscence. While he admits that he misses practicing medicine, which he quit in 1989 when the demands of advocating for the OHP precluded doing both, he believes he can accomplish far more good in his present endeavor. Kitzhaber's focus on his goal is clear and his instinct to broaden the context of his experience prevails. "This campaign is not just about electing me governor," he says. "It has to set the stage for accomplishing something, for dealing with the problems faced by our state. Because, ultimately, I don't want to be governor; I want to govern." MM

Mark Gibson, owner of Northwest Passage Consulting in Monmouth, Oregon, specializes in resource allocation policy and public outreach processes. He was Kitzhaber's chief of staff when Kitzhaber was president of the Oregon Senate.

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News For Minnesota Physicians

Announcements

Provider Network Seminar Is January 11

The Minnesota Medical Association, the Minnesota Hospital Association, and the Minnesota Medical Group Management Association will present a seminar on cooperatives, clinics without walls, and other provider-sponsored networks January 11, from 9 a.m. to 4 p.m. at the Northland Inn in Brooklyn Park. The registration fee is $75 for members and $125 for nonmembers. For more information, call Vicki Westling, 612/378-1875 or 800/999-1875.

How Does Cultural Diversity Affect Patient Outcomes?

Attend the conference,
"Through the Eyes of Others: Is Health Care Culturally Competent?"
February 14, 1995,
8 a.m. to 5 p.m.,
Earle Brown Continuing Education Center, St. Paul

The keynote speaker is Lonnie Bristow, M.D., president-elect of the American Medical Association. This continuing education conference for physicians is sponsored by the Hennepin County Medical Society and the United Way of Minneapolis Area. For more information, call Nancy Bauer, 612/623-2893.

MMA Will Draft Health System Reform Bill

At the 141st MMA Annual Meeting in St. Cloud, the 1994 MMA House of Delegates unanimously adopted a resolution calling on the MMA Board of Trustees to develop health system reform legislation to introduce during the 1995 legislative session.

This initiative arose out of the controversial Resolution 26 calling for a study of the single-payer system. In open hearings before Reference Committee C, physicians discussed whether it was too late to change the direction of MinnesotaCare by calling for a single-payer plan. Delwin Ohrt, M.D., senior vice president of Blue Plus, said, "The train has left the station. Do you think you can turn it around?"

"At this point, the train has slowed enough to get on board and affect the direction," said Burton Schwartz, M.D., a Hennepin County Medical Society delegate.

The amended Resolution 26, adopted by the House of Delegates, does not mention a single-payer study, but is much wider and more sweeping in scope. The resolution reaffirms the MMA's eight Principles for Health Care Access and Reform; finds that no current plans or proposals fully meet these principles; and resolves that the MMA will study all proposals for alternative payment, financing, and purchasing systems, including broad issues of improved patient care, minimization of bureaucracy, decreased costs, and an environment in which physicians can deliver quality patient care. Using this study, the MMA Board of Trustees will develop legislation to introduce during the 1995 session. The final resolve calling for an MMA-drafted bill was adopted as an amendment on the floor of the House of Delegates.

"This bill will not be a complete repudiation or re-writing of the MinnesotaCare legislation," said Andrew J.K. Smith, M.D., president of the MMA. "Some parts of MinnesotaCare are good and some are not." He suggested that the MMA include in its bill provisions to achieve universal coverage through market reforms, proposals for a broad-based funding source, and a repeal of the regulated all-payer option (RAPO).

Delegates expressed strong support for the amended resolution, but many stressed that it is a major commitment. MMA CEO Paul Sanders, M.D., told the House of Delegates that it is crucial to reach a consensus of the full MMA membership for such a major and expensive commitment. "This will require a great deal of staff time and expense and it will occur during a three-month time crunch," he said.

The MMA Board will be faced with the challenging task of developing legislation that will win strong backing from MMA members. The legislation will be based upon existing MMA policy on specific issues as well as upon the eight principles of health care reform. (See pages 35-37.)

Despite the difficulties of this major undertaking, delegates responded to the challenge. Thomas A. Stolee, M.D., past president of the MMA, said, "Let's go for it."

Viewpoint

• • •

Andrew J.K. Smith, M.D.
President, Minnesota Medical Association

Finite Resources Force Difficult Choices

One of the major questions we face as a society is how to allocate finite health care resources. We can't afford to provide unlimited health care services to everyone. The question is—how can we use our resources in a way that is fair and sensible?

Despite the relevance of this question to state policy and legislation, there is no consensus. In this issue of *Minnesota Medicine*, Steven Miles, M.D., describes a public opinion survey sponsored by the Medica Foundation, showing that people hold contradictory beliefs on resource allocation. Most people believe everybody should have the right to the best possible health care. One-third of the people surveyed believe that insurance should pay for a very expensive test that the physician says is not necessary. At the same time, most people realize no insurance company can pay for all possible care.

Clearly, there is a need for public education, discussion, and debate. Choices about how to allocate health care resources plunge us into a minefield of moral dilemmas and contradictory beliefs. Nobody wants to say no to a procedure that could save even one person's life.

But resources are limited. The MinnesotaCare legislation sets a global limit on how much health care spending can increase each year. Integrated service networks will have to provide services to a certain number of people for a fixed amount of money. Capitated physicians must provide care for their patients within a fixed budget.

Even if MinnesotaCare had never passed, rising costs would still force us to face the fact that resources are finite. In 1992, health care consumed 14 percent of the gross national product, dwarfing education at 6 percent and defense at 4.8 percent. Biotechnology and medical research continue to generate new and sometimes more expensive treatments. There are still 400,000 Minnesotans without health care insurance despite state efforts to improve access. With these financial pressures, hard choices are inevitable.

The question of how to allocate resources underlies several major decisions facing the 1994 Minnesota Legislature. As the Medica Foundation survey underscores, there is wide public support for universal health care coverage. But are Minnesotans willing to back up this belief with their tax dollars? Will they support higher taxes to help subsidize those who can't afford to pay for health care? We have no clue, because so far legislators have avoided the issue of adequate long-term funding for MinnesotaCare.

This year the MMA will force public debate out into the open by introducing a bill that calls for broad-based funding to provide health insurance for the uninsured, and will also promote a comprehensive list of medical services that should be included in any guaranteed universal benefits set (see page 46). Physicians must play the primary role in defining basic medical care, but there must also be public recognition of the costs involved in providing benefits to everyone.

As physicians, we are in a position to provide information and help inform the debate on resource allocation. The trade-offs are not clear to most people.

We can help clarify community values about resource allocation in the following ways:

- Raise public awareness of the ethical issues involved in choices.
- Explain that money spent on health care that is inappropriate or doesn't work reduces the amount of money available for health care procedures that do work.

Most families work within a budget. They don't have enough money to buy everything they want, so they talk about how to spend their money. What's best for everyone in the family? What do we need? What can we afford? Our society faces the same questions regarding health care spending. And, like the family, society must decide how it will make those decisions.

More information will help to clarify the issues. Outcomes research will help determine which procedures are most effective. In a Medica roundtable discussion in May 1994, when participants were faced with allocation decisions, they wanted to know how many people a given treatment would help and how well it would work. They asked: Will it save lives? How many? How will it affect quality of life?

Practice guidelines based upon outcomes research will help physicians make wise treatment decisions. Information on the value of technologies will also help in decision making.

We physicians will play a vital role in stimulating the discussion and helping to reach a consensus on how to allocate resources, but we can't do it alone. • • • • •

MMA Principles for Health Care Access and Reform

In 1991, the Minnesota Medical Association Board of Trustees adopted a position paper setting forth eight principles on which to base health system reform and listed specific provisions to be included in any state plan. This position paper, "Health Care Access and Reform," was reaffirmed by the MMA House of Delegates in amended Resolution 26 and will serve as a basis for the MMA-drafted bill to be proposed in 1995. The eight principles and key strategies to support them are listed below.

1. All Minnesotans are entitled to a basic level of health care.

2. Individuals, employers, and the government all have an obligation to ensure adequate coverage of all citizens.

- Require every citizen to have coverage for basic health care.
- Require any health plan, public or private, to use the MMA Medical Benefits Task Force report as the model for providing a basic level of care.
- Emphasize primary and preventive services.
- Use mechanisms such as co-pays, deductibles, and prior authorization to encourage the proper use of health care services.
- Provide state assistance on a sliding scale to those who cannot afford health coverage.
- Give employers incentives to offer basic coverage to employees and their dependents.
- Give individuals tax incentives to buy basic health coverage.

3. Reforms must be implemented to improve the effectiveness and quality of care.

- Involve professional medical organizations in coordinating and disseminating practice parameters.
- Base data initiatives on scientifically valid research and analysis.
- Use peer review for educational purposes.

4. Insurance must be portable for individuals changing jobs or moving to other parts of the state.

- Establish premium rates for individuals and small groups on a carrier-specific, statewide community-rated basis to allow risk to be spread among all insured people.
- Prohibit pre-existing condition clauses or denial of coverage on the basis of health status.
- Allow health plans to use reinsurance mechanisms in order to share risk.

5. Cost containment must be achieved while maintaining a high quality delivery system.

- Cut administrative costs by using standardized claim forms, billing procedures, and utilization review criteria.
- Review issues and costs related to technology.
- Develop a system to facilitate the appropriate, cost-effective use of prescription drugs.
- Maintain a multi-payer system to preserve patient choice.
- Address the health care costs caused by the current tort system.
- Address the antitrust implications for health care facilities of sharing services.

6. Geographic access must be assured throughout the state of Minnesota.

- Develop programs to help communities recruit and retain health professionals.
- Help communities develop local plans to assure continued geographic access to care.

7. Public education and health promotion efforts must be expanded.

- Increase efforts to achieve a smoke-free society by the year 2000.
- Increase funding for health promotion and disease prevention.
- Develop an educational campaign on the appropriate use of the health care system.

8. An adequate broad-based funding source must be dedicated to ensuring universal coverage.

- Because the health care access problem demands a societal solution, funding must come from many sources. Funding should be raised from each of the following sources and dedicated to assuring access to health care for all Minnesotans: tobacco taxes, alcohol taxes, and income taxes. A payroll tax on employers with credits for employers subsidizing health coverage should also be promoted.

• • • • •

Supreme Court Will Hear Surcharge Case

• • • • • The Minnesota Supreme Court has decided to hear an appeal of the physicians' class action seeking refunds of the $400 surcharge on medical licenses issued or renewed from April 1 to September 30, 1992. Physicians contend that it was illegal for the state to require them to pay the surcharge because the tax law didn't take effect until October 1, 1992. They also argue that the retroactive tax violated their constitutional guarantees of due process and equal protection.

In June, however, the Minnesota Court of Appeals ruled against the physicians and upheld a District Court ruling that the surcharge was not applied retroactively because it applied to all physicians licensed under Minnesota law on the effective date of the statute, October 1, 1992. Now the physicians have another chance to make their case.

The MMA House of Delegates, by adopting Resolution 35, reaffirmed MMA opposition to the $400 license surcharge for all physicians and resolved to continue efforts to gain repeal at the state and national level.

MMA Develops Framework for Patient Care Bill

At a special meeting October 22, the MMA Board of Trustees reviewed a framework and general direction for the Minnesota Medical Association bill—the Patient Care Bill—to be introduced during the 1995 legislative session. This bill will refocus the state's reform efforts on private market reforms and on achieving universal health care coverage. It will also attempt to increase accountability for health plans, providers, and the government.

More research is needed before the MMA can develop the specific provisions of the bill, but the following summary suggests some ideas that might be included or might serve as the basis for further research and consideration.

Universal Coverage

Enforcement of the Mandate

The 1994 MinnesotaCare legislation requires every Minnesotan to have health care coverage by 1997. The MMA might propose a way to enforce compliance with this mandate. There are several possibilities. Tax incentives or driver's license renewal requirements might be used to encourage people to buy coverage. The personal deduction on the income tax forms might be used as an incentive; if coverage was not purchased, the $2000 per person deduction would be lost. The MMA will continue to consider ways to put teeth in the mandate.

Insurance Reforms

The current MinnesotaCare legislation requires that by July 1, 1997, all health plans sold in Minnesota must be guarantee issued, community rated within a class, have no pre-existing condition exclusions, and have no underwriting restrictions. The MMA supports these reforms and will consider whether it would be possible to strengthen them.

Expansion of MinnesotaCare Enrollment

The MMA may call for an expansion of MinnesotaCare eligibility by providing subsidized coverage with a sliding scale for individuals and couples who earn up to 275 percent of the poverty level. The eligibility limit has been held to 125 percent for people without dependent children because of the state's budget shortfall.

Broad-Based Funding

MMA policy supports the repeal of the 2 percent tax, adoption of a broad-based funding source for MinnesotaCare, and a dedicated fund to be used for health care.

Last year, the MMA supported a progressive income tax increase and a 40 cent per pack increase in the cigarette tax for five years to fund subsidies for low-income people in the MinnesotaCare program. Other funding possibilities under discussion are:

- an income tax surcharge;
- an excise tax on alcohol;
- a payroll tax, shared by employer and employee;
- a "free rider tax" on those who do not purchase health care;
- a tax on guns and ammunition.

Further study is needed to identify a combination of funding sources that would be adequate and that would have a realistic chance of passing and being signed into law.

Government Accountability

The MMA will consider ways to reduce any unnecessary bureaucracy so that scarce state money is used to pay for health care for the uninsured. This may entail re-evaluating the roles of the various MinnesotaCare boards and advisory committees to make sure there is no duplication of efforts.

Announcements

MMA House of Delegates Elects MMA Officers

The MMA House of Delegates elected the following officers:

President-elect
Michael J. Murray, M.D.

Vice president
Raymond G. Christensen, M.D.

Secretary
Thomas B. Dunkel, M.D.

Treasurer
Eric Reeber, M.D.

Speaker of the House
Barbara P. Yawn, M.D.

Vice Speaker
Anthony C. Jaspers, M.D.

The following AMA delegates were elected:

Robert D. Christensen, M.D.
E. Duane Engstrom, M.D.
Audrey M. Nelson, M.D.
Richard B. Tompkins, M.D.

The following alternate delegates were elected:

Frank J. Indihar, M.D.
Theodore L. Fritsche, M.D.
C. Randall Nelms, M.D.
Carolyn J. McKay, M.D.

The following trustees were elected:

James L. Anderson, M.D., Northeast
Robert Milligan, M.D., North Central
Paul C. Matson, M.D., Southwest
David C. Herman, M.D., Southeast

Timothy J. Crimmins, M.D., was elected chair of the MMA Board of Trustees at a board meeting immediately following the MMA Annual Meeting.

Regulated All-Payer Option

The MinnesotaCare Act requires that after July 1, 1997, all health care that is not delivered through integrated service networks (ISNs) or community integrated service networks (CISNs) must be delivered through the regulated all-payer option (RAPO), which will have a mandatory fee schedule. The MMA may ask the state to repeal RAPO and allow physicians and payers to meet their spending and revenue targets though the delivery system that best meets their patients' needs.

The MMA will consider other ways to develop an accountable fee-for-service system and to promote patient choice of health plans. The MMA may look closely at initiatives in current law that are designed to encourage small purchasers to pool together so they can offer cheaper premiums and more choice. For example, the 1994 MinnesotaCare Act permits the creation of voluntary purchasing pools of 1,000 members. More study is needed to determine if strengthening the purchasing pool concept would be preferable to RAPO.

Regional Coordinating Boards

The RCBs were originally proposed in 1992 when the Legislature was contemplating a certificate of need. The certificate of need provision was dropped, but the RCBs remained in the final 1992 legislation without being given a clear role to play. Some RCBs planned to review ISN and CISN applications but discovered they can't do that because of data privacy laws. The MMA will consider whether RCBs should continue or whether the responsibility for obtaining regional input on health care should be transferred to the community health boards.

Health Technology Advisory Committee and the Practice Parameter Advisory Committee

The MMA believes the state should continue to encourage the appropriate use of technology and the use of practice parameters, but should reduce costs by consolidating efforts whenever possible. The MMA will study the roles of these two advisory committees.

Data Collection

The MMA may propose that the Minnesota Department of Health (MDH) be required to identify goals and costs before launching a data collection effort. The MMA will also consider the role of the Minnesota Health Data Institute, which is currently an advisory body to the commissioner of health, to determine whether its authority should be strengthened and its functions clarified.

Cost Containment

Tort Reform

The MMA bill may include some of the following reforms based on the California Medical Injury Compensation Reform Act (MICRA), which have been shown to reduce costs:

- Cap on non-economic damage awards of $250,000;
- Sliding-scale cap on attorney contingency fees related to the size of the award;
- Periodic payments for large awards;
- Mandatory offsets for collateral sources of payment;
- Stronger process to certify claims as having merit.

Administrative Efficiencies

The MMA is working with the state on efforts to develop standardized billing and other administrative efficiencies. It is unlikely that more legislation will be needed.

Health Plan Accountability

The MMA will propose a number of provisions designed to hold payers accountable and to improve patient choice. The MMA will draw upon the Patient Protection Act (PPA) in developing these initiatives. Many of the provisions in the PPA are already included in Minnesota law. Existing Minnesota law requires all utilization review (UR) staff to be "properly trained, qualified, and supervised," and requires licensed physicians to review any case before making a denial. Minnesota law also requires the UR organization to have written procedures explaining how determinations are made and requires them to provide an appeals mechanism for patients and the attending physicians.

The MMA bill may propose additional provisions. Some possibilities under discussion are listed below:

- Require health plans to offer a point-of-service option.
- Preserve the individual's right to pay for services outside of the health plan and basic benefits package.
- Require that health plans provide enrollees with information that is not misleading about the types of providers in the plan's network.
- Require that the criteria used to select physicians for the health plans be made available to the public.
- Prohibit prior authorization requirements and retrospective denial for emergency care.
- Provide incentives to health plans to offer enrollees options and choice of providers.

It is not possible to require employers to offer a choice of more than one health plan because of the federal Employee Retirement Income Security Act (ERISA), which prevents state regulation of employers' benefits plans, but the MMA will consider other ways to improve patient choice.

Flexibility, Local Options

The MMA will propose ways to help local communities and physicians develop networks to compete with the large health plans. More research is needed on this issue.

This preliminary framework approved by the MMA Board rests upon a bedrock of existing MMA policy and sets a clear direction, but the details need to be filled in and legislative language drafted. The MMA will seek members' reactions to these preliminary proposals. Overwhelming member support will be needed to pass the MMA bill.

The MMA wants to hear from you. Call 800/DIAL-MMA (800/342-5662) and record your response to the proposed framework for the MMA's Patient Care Bill. • • • • •

MMA Presents Awards

The Minnesota Medical Association held an awards lunch September 29 as part of the MMA's 141st Annual Meeting in St. Cloud.

'Stop the Violence' Award

The Minnesota Medical Association presented the first annual "Stop the Violence" Award honoring efforts to put an end to domestic violence and abuse to:

- Duluth Domestic Abuse Intervention Project;
- Susan Hadley, founder of WomanKind; and
- A. Stuart Hanson, M.D., Minneapolis physician.

The Duluth Domestic Abuse Intervention Project was formed in 1981 when nine city, county, and private agencies came together to coordinate support services for victims, rehabilitation programs for offenders, and, when necessary, legal sanctions or the incarceration of an assailant.

Susan Hadley is the founder and director of WomanKind, a support system for battered women at Fairview Health System.

A. Stuart Hanson, M.D., during his 1992 term as president of the Minnesota Medical Association, initiated a campaign against domestic violence and abuse that has won awards from Gov. Arne Carlson, from the Minnesota Society of Association Executives, and from the American Society of Association Executives. Hanson specializes in pulmonary disease and internal medicine at Park Nicollet Medical Center in Minneapolis.

Articles on the Duluth Domestic Abuse Intervention Project, Hadley, and Hanson appeared in the October issue of *Minnesota Medicine*.

New Award for Service to Minorities

The MMA presented a posthumous Award for Meritorious Service to Minority Populations to Alexander Abrams, M.D. For many years, Abrams provided medical services primarily to a poor, largely minority population in St. Paul. He was well known and respected throughout his community for helping people who could not afford to pay for medical care. Abrams also participated in the Selby Avenue Commercial Club and served on the Board of Directors of the Hallie Q. Brown Community Center. This is the first time this award has been presented. Dana Abrams accepted the award on behalf of her father who died in 1992.

President's Awards

The MMA granted the President's Award to the following MMA members who have made outstanding contributions to the medical profession through their service in the MMA: Maurice J. Martin, M.D., Rochester; H. Dawes Miller, M.D., Plymouth; Eugene C. Ott, M.D., Minneapolis; Richard E. Student, M.D., Minneapolis; and George V. Tangen, M.D., Minneapolis.

Hoban Honored

Thomas W. Hoban, chief executive officer and executive vice president of the Hennepin County Medical Society, received the Shotwell Award at the MMA inaugural dinner. The Shotwell award is presented annually for a noteworthy effort in the health care field in Minnesota. Hoban was also honored at the MMA House of Delegates meeting for his "dedication, commitment, and eloquent advocacy on behalf of the HCMS and organized medicine for the past 25 years."

Community Service Award

The winners of the 1994 Physician Awards for Community Service are Howard A. Andersen, M.D., Charles E. Crutchfield, M.D., and Hugh Westgate, M.D. Andersen, a pulmonary disease physician on the emeritus staff of the Mayo Clinic in Rochester, has been working to improve the environment for more than 30 years. He was appointed by five successive governors to various committees on air and environmental quality. Crutchfield, chair of the Obstetrics and Gynecology Department of United Hospital in St. Paul, devotes long hours to helping the youth in his community. Active in "Remember Rondo Days," an annual celebration in St. Paul's African American community, he is considered an influential community leader and role model. Westgate, who retired as director of anesthesia services at Fairview Ridges Hospital in Minneapolis, continues teaching and volunteering his medical services in developing countries. Westgate has helped set up clinics in Thailand, Laos, and Costa Rica, as well as an open-heart center in San Jose, Costa Rica.

Sova Award

The Minnesota Medical Association presented the James H. Sova Memorial Award to Sister Mary Madonna Ashton. This award is given to a person, not of the medical profession, who has made a significant contribution to the advancement of medical sciences, medical education, medical care, or the socioeconomics of medical practice. A former commissioner of health, Ashton is the president and chief executive officer of the Carondelet LifeCare Ministries and the Carondelet LifeCare Corp. in Minneapolis.

Communicator Award

The MMA presented the Physician Communicator Award to Edmund C. Burke, M.D., who writes the column "Healthy Kids," which was formerly published in the *Rochester Post Bulletin* and now appears in the publication, *Rochester*. He was also the editor of the MMA journal *Minnesota Medicine* for three years. Burke is an emeritus consultant at Mayo Clinic and an emeritus professor at the Mayo Medical School in Rochester. • • • • •

Robert Christensen, M.D., Receives MMA's Highest Award

Robert D. Christensen, M.D., received the Distinguished Service Award, the highest award given by the Minnesota Medical Association. Christensen was honored for his many years of leadership and service in the MMA and for his outstanding contributions to medicine at the president's inaugural dinner September 29 during the MMA's 141st Annual Meeting.

A board-certified general surgeon, Christensen is the regional director of the Park Nicollet Medical Center and an associate professor in the Department of Surgery at the University of Minnesota Medical School in Minneapolis. He has served as MMA president, as a member of the MMA Board of Trustees, as board chair, and as a member of many MMA committees. Currently, he is a delegate to the AMA. • • • • •

Robert D. Christensen, M.D., and his wife, Nancy.

MMIC Policyholders Will Receive $4 Million Premium Credit

• • • • • The Midwest Medical Insurance Company (MMIC) Board of Directors has approved a retrospective premium credit of nearly $4 million for those Minnesota policyholders who were insured in 1992 and 1993 and who renew their policy in 1995. A credit of approximately 15 percent of the renewal premium will be applied to the second quarter 1995 billing.

George Tangen, M.D., chair of MMIC, said, "It is always a pleasure to announce good news for our physician owners—especially in these days of uncertainty. The retro premium credit program was implemented in 1992 and has resulted in nearly $6 million being returned to our Minnesota policyholders in its first two years."

MMIC also announced that the 1995 rate level will remain the same as it was in 1994. This means that rates have either gone down or remained the same every year since 1989. As a result, most MMIC insureds are paying less today for coverage than they paid in 1988.

"These milestones are especially gratifying now during the uncertainty created by health care reform," said Tangen. "Physicians started MMIC to escape the 'boom and bust' pricing cycles of the '70s and '80s. They wanted a long-term, consistent insurance carrier, a goal that could only be achieved by creating a company owned by the policyholders. When you pay premiums to MMIC, you pay them to yourself since there are no outside investors."

"MMIC has operated with a conservative and consistent approach for almost 15 years," Tangen said. "This approach will continue to serve the physician owners best by maintaining a financially secure company and returning profits to its physician owners—not to non-policyholder shareholders."

Senate Candidates Address House of Delegates

Rep. Rod Grams, IR, spoke against a single-payer health care plan at the MMA Annual Meeting in St. Cloud. In an address to the MMA House of Delegates, he charged that a single-payer system would threaten quality of care, force rationing, eliminate fee-for-service medicine, make physicians government employees, and destroy the physician-patient relationship. "Each member of Congress should take a bureaucratic oath to first do no harm," he said. Grams supports the Consumer Choice Health Security Act. A former television newscaster, Grams was elected to represent Minnesota's sixth Congressional district in 1992. He was elected freshman congressional whip, authored several budget-cutting measures, and introduced a medical malpractice reform bill. MEDPAC has endorsed Grams for the U.S. Senate.

Senate candidate Ann Wynia told the MMA House of Delegates she is not wedded to a particular health care bill but would base her position on the following set of principles: universal health care coverage, comprehensive medical benefits, patients' right to choose a provider, and states' ability to experiment. One state option should be the single-payer plan, she said. Wynia has served as a state representative, as majority leader of the Minnesota House of Representatives, and as the Minnesota commissioner of human services. She authored Minnesota's Children's Health Plan legislation and the first bill that added state funds to the Head Start Program. She supports a similar proposal before the U.S. Congress. "Health care for children would save billions in future health care costs not to mention educational and social service costs," she said. Wynia was awarded the AMA's distinguished Dr. Nathan B. Davis Award. • • • • •

MMA Adopts Policy on Handguns and Automatic Repeating Rifles

In heated testimony before Reference Committee D, opponents of gun control squared off against those who argued passionately that the Minnesota Medical Association must take a strong stand on this public health issue.

Judith G. McGahey, M.D., a family practice physician from Moorhead, said that countries that do not allow private citizens to own handguns have a 50 percent lower adolescent suicide rate than the United States. Urging the MMA to support restrictions, she said, "Rarely does someone use a gun to protect his family. Usually it is a deranged family member who, when he feels trapped, kills himself or his family."

Gun control opponents stressed that it is impossible to end murders and suicides by eliminating one weapon. One physician recalled a farmer who was so depressed he burned all the rope on his farm so he wouldn't hang himself.

The MMA House of Delegates stopped short of adopting tough AMA policy related to handguns and automatic repeating weapons, but came down firmly in favor of collecting more data on the use of guns and in support of educational programs on the dangers of keeping firearms in the home. The House also adopted in amended Resolution 39 those elements of AMA policy that had broad member support.

The most controversial of the adopted AMA policies regarding handguns and automatic weapons supports the right of local jurisdictions to enact firearm regulations that are stricter than state statutes and encourages state and local medical societies to evaluate and support local efforts to enact useful controls.

There was strong testimony on both sides of this issue. Opponents, including Theodore Fritsche, M.D., argued that it would create a "patchwork of laws" and make criminals of people who drove through the cities with a gun in their car. A. Stuart Hanson, M.D., urged delegates to allow cities to control the proliferation of handguns. "I live in the same neighborhood in South Minneapolis where I grew up," he said. "I don't want to move away from my home. But if the city of Minneapolis can't do more to control handguns, I can't live there anymore. It's not safe." The MMA House adopted this AMA policy.

The MMA House also voted to support the destruction of any weapons obtained in local buy-back programs *after checking to determine whether the gun is evidence from a crime or stolen property.* The latter provision was added to allay fears that this AMA policy would allow some criminals to go free because the "smoking gun" had been destroyed.

The MMA supported AMA policy calling for stricter enforcement of current federal and state gun control legislation and mandated penalties for crimes committed with a firearm, including the illegal possession of a firearm, and, in addition, supported waiting periods and background checks for purchasers of handguns and automatic repeating weapons.

The MMA rejected AMA policies supporting legislation restricting the sale and private ownership of large-clip, high-rate-of-fire automatic and semi-automatic firearms and legislation outlawing Black Talon and other similarly constructed bullets.

Educational programs were much less controversial. The MMA House voted to support and promote educational programs to reduce the number of deaths and injuries caused by firearms and to alert the public to the dangers of keeping firearms in the home. (Substitute Resolution 42.)

The MMA will also develop an educational campaign for physicians that will:

- encourage physicians as part of general patient history taking to ask patients/parents if they have a firearm and, if so, whether the ammunition is stored apart from the firearm;
- encourage physicians to ask depressed patients and their families whether they have access to firearms;
- encourage physicians to provide information or resources on how to safely store a firearm to patients who choose to keep a firearm in the home. (Amended Resolution 43.)

To strike at the root of violence, the MMA will support the expansion of conflict resolution and reconciliation training in educational settings (kindergarten through 12th grade) and parenting classes. (Amended Resolution 44.)

The three resolutions calling for gathering information on the use of firearms had wide support and passed easily. Fritsche said, "We base treatment decisions on sound data. But regarding gun control, we look at anecdotes and headlines, not at the data." To address this lack of information, Resolutions 31, 40, and 41 were combined into Substitute Resolution 31 and adopted.

The MMA will work with the Minnesota congressional delegation to encourage:

- the federal government to resume asking questions on the National Health Interview Survey about firearm-related injury as was done prior to 1972;
- Congress to mandate that the Centers for Disease Control and Prevention develop a national firearm fatality reporting system; and
- the National Electronic Injury Surveillance System to begin tracking firearm-related injuries.

The Minnesota delegation to the AMA will bring a similar resolution to the AMA.

The MMA will also support efforts to expand the scope of the mortality study conducted by the Firearm Injury Prevention Task Force to include new data beyond 1988, will encourage the appropriate state agency to collect data and develop a study on the number of firearms in schools and the misuse of firearms by Minnesota youth, and will encourage the state to share the results of such a study with the MMA.

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MMA House of Delegates Votes on 1994 Resolutions

At the Minnesota Medical Association's 141st Annual Meeting in St. Cloud September 29-31, 1994, the MMA House of Delegates adopted resolutions that will guide the association in the coming year. A summary of the action of the 1994 MMA House of Delegates follows.

Report 5A, MMA Treasurer

Three motions were adopted.

1. That the dues for regular active MMA members be increased from $440 to $460 per year.
2. That the Operations Budget for FY 1995 be approved.
3. That the Capital Budget for FY 1995 be approved.

Res. 1, Accountability of Government Peer Review Organization and Data Collection Services

Adopted as amended.

The MMA will support policy that all certifying or accrediting agencies, government or private, should include cost savings or proven patient outcomes in their standards justifications based on improved patient care. The MMA delegation to the AMA will submit a resolution supporting the same policy at the national level and calling on the AMA representatives on any certifying and accrediting organizations to urge creation of standards and review current standards based on this policy.

Res. 2, Weekend Nursing Home Transfers, was withdrawn by the author because Res. 17 addressed his concerns

Res. 3, Organized Medical Staffs and MMA-HMSS

Adopted as amended.

The MMA supports the concept of representatives from other organized non-hospital medical staffs serving as representatives to the MMA Hospital Medical Staff Section, and resolves that the MMA HMSS be authorized to propose and recommend the policy defining the eligibility criteria and role for the organized non-hospital medical staffs.

Res. 4, Insurance Discrimination

Adopted as amended.

The MMA will oppose denial of insurance coverage to victims of domestic violence and abuse and will seek legislation to prohibit insurance discrimination in Minnesota. The MMA delegation to the AMA will forward a similar resolution to the AMA's House of Delegates.

Res. 5, Sleep Deprivation Survey

Adopted.

The MMA will work with the American Sleep Disorders Association and other appropriate groups to develop and disseminate a survey to evaluate Minnesota Independent School Districts' response to the MMA's letter regarding early start times and to assess school hours, the inclusion of sleep-related materials in the school curriculum, and the incidence of sleep-related accidents among students.

Res. 6, Sexual Discrimination and Harassment

Adopted as amended.

The MMA will continue public educational initiatives regarding sexual discrimination and harassment, and the MMA delegation to the AMA will bring a resolution to the AMA requesting educational initiatives on the national level, to include working with the major television networks, the Writer's Guild, and developing public service announcements.

Sub. Res. 7, Commendations

Adopted in lieu of Resolutions 7, 38, 46, 47, 49, 56, 58, and 59.

The MMA House of Delegates commends the following people for their dedicated service and contribution to the MMA: 1) Gail L. Gamble, M.D., for her years of effective and competent leadership as trustee, speaker of the House of Delegates of the MMA, and chair of the MMA Board of Trustees; 2) C. Randall Nelms Jr., M.D., for his leadership, dedication, and enthusiasm as MMA president-elect and president; 3) Thomas W. Day, M.D., for his dedication and commitment to the medical profession and as an MMA trustee; 4) David Van Nostrand, M.D., for his dedication and tradition of excellence as an MMA trustee; 5) Anthony C. Jaspers, M.D., for his energy, time, and talent as MMA trustee; 6) Theodore L. Fritsche, M.D., for his dedicated service and leadership on various MMA committees and as an MMA trustee; 7) Thomas W. Hoban for his dedication, commitment, and eloquent advocacy on behalf of the Hennepin County Medical Society and organized medicine for the past 25 years; 8) Robert Kelly, M.D., for his enthusiasm and distinguished record of service to his community, region, state, component medical society, the MMA, and the AMA.

Res. 8 and Res. 9, Bylaws Revision

Adopted.

The bylaws revisions, which were approved by the MMA Board of Trustees, were adopted.

Res. 10, Mandated Content of Continuing Medical Education

Adopted as amended.

The Minnesota Medical Association reiterates its current policy opposing any legislation or government regulation that defines the subject matter content of continuing medical education required for physician relicensure in Minnesota.

Res. 11, Culturally Competent Health Care

Adopted as amended.

The MMA will study and recommend ways in which increased education on intercultural issues should become a part of medical student

Resolutions continued on page 42

Resolutions continued from page 41

and resident training, and the MMA will help to educate Minnesota physicians about issues related to intercultural health care.

Res. 12, Interpreters

Referred to the Board of Trustees for study and action.

Be it resolved that the MMA, through the MMA Guaranteed Benefits Set, support language translation services as a covered benefit, and that the MMA encourage the ongoing activities of those groups and organizations dedicated to improving the quality of health care delivered to intercultural communities.

Res. 13, HCMS Abuse Prevention Project

Adopted as amended.

The MMA will help to educate Minnesota physicians regarding issues of violence and abuse in the medical workplace.

Res. 14, Categories of Membership

Adopted as amended.

The MMA will work closely with component medical societies to establish common categories of membership throughout the state and will consider AMA membership categories when developing common categories of membership.

Res. 15, Medicare Reimbursement Inequities

Adopted as amended.

The MMA will work with the Minnesota Legislature, the governor, and the Minnesota attorney general to obtain adequate appropriation from the 1995 Legislature to enable the attorney general to initiate legal action against the federal government to correct the geographic inequity in Medicare reimbursement under both fee-for-service and capitated arrangements.

Res. 16, Physician Involvement with Third-Party Payers

Adopted as amended.

The MMA will encourage third-party payers, ISNs, CISNs, and other similar organizations to formally and significantly involve physicians on their boards of directors and advisory councils.

Res. 17, Timely Nursing Home Transfers

Adopted.

The MMA will identify barriers to timely transfer of patients from hospitals to nursing homes and will work with physicians, nursing homes, and others to decrease barriers to nursing home transfers.

Res. 18, Urgent Care Centers

Referred to the Board of Trustees for decision.

Be it resolved that the MMA conduct a study of urgent care centers in order to determine what are the physician qualifications required and whether they have a formal credentialing process including the initial appointment and reappointment application, and that the MMA review and, if necessary, establish standards for physicians providing services at urgent care centers.

Sub. Res. 19, AIDS Testing

Adopted.

The MMA reaffirms its current HIV testing policy, which reads as follows: The MMA Board of Trustees will continue to study HIV testing issues and suggest modifications of MMA policies in accordance with nationally accepted principles based on sound scientific rationale.

Sub. Res. 20, Bicycle Safety

Adopted.

The MMA reaffirms its existing policies on bicycle safety and bicycle helmet use which reads as follows:

Bicycle safety: The MMA supports legislation that mandates the use of approved protective helmets for minors when riding bicycles, snowmobiles, or two-, three-, or four-wheel motorized recreational vehicles in the state of Minnesota.

Bicycle helmet use: The MMA supports the passage of legislation designed to significantly increase bicycle helmet use in children and adults. The MMA will undertake efforts to increase public awareness that all persons riding bicycles should wear tested and approved bicycle helmets, and recommends bicycle helmet use by any person riding a bicycle.

Res. 21, Water Safety

Referred to the Board of Trustees for study and for report back to the House of Delegates in 1995.

Be it resolved that the MMA support legislation that mandates the use of life jackets or flotation devices for children under age 18 on watercraft on navigable waters, not to include commercial watercraft that are complying with Coast Guard regulations and providing proper emergency floatation devices.

Res. 22, Reimbursement for Mid-Level Practitioners

Adopted as amended.

The MMA will pursue fair reimbursement for physician-supervised services provided by nurse practitioners, nurse specialists, and physician assistants.

Sub. Res. 23, Health Plan Restrictions on Mental Health and Chemical Dependency Treatment by Primary Care Physicians; Mental Health Treatment Restrictions

Adopted in lieu of Resolutions 23 and 25.

The MMA will support efforts to end discriminatory restrictions on the treatment of mental illness and addictive disorders, and will support removal of health plan restrictions on appropriate mental illness and addictive disorder treatment by primary care physicians, and the Minnesota delegation to the AMA will carry such a resolution to the AMA.

Res. 24, Retention of Physician Signature on Vital Statistics Information

Adopted as amended.

The MMA will work with Department of Health representatives and communicate the MMA's concern that the automated Vital Statistics system retain the physician signature on the original birth and death certificates if retention of the signature on copies is economically feasible.

In lieu of Res. 25, Sub. Res. 23 was adopted

Res. 26, Health System Reform

Adopted as amended.

The MMA reaffirms its Principles for Health Care Access and Reform. The MMA finds no current plan or proposals for health system reform fully satisfactory in meeting these principles. The MMA will continue to monitor and study all proposals for alternative payment, financing, and purchasing systems, and this evaluation will include broad issues of improved patient care, minimization of bureaucracy, decreased costs, and an environment in which physicians can deliver quality patient care. The Board of Trustees will use this evaluation to develop a legislative bill for the 1995 Legislature.

Res. 27, Support of Patient Protection Act

Adopted.

The MMA publicly supports the Patient Protection Act of 1994, encouraging Minnesota's congressional delegation to secure its passage, and the MMA will actively pursue the inclusion of appropriate provisions of the Patient Protection Act of 1994 in Minnesota state law.

Res. 28, Reporting of Administrative Costs in Health Care Spending

Adopted as amended.

The MMA will work with the Minnesota Health Data Institute, the Minnesota Department of Health, and other appropriate agencies to develop reporting methods for health care expenditures that will give the public an accurate accounting of where resources are spent in the health care system including all resources spent on administrative services.

Res. 29, Study of the Impact of the $400 Physician License Surcharge on Medicaid Reimbursements

Referred to the Board of Trustees for study.

Resolved that the MMA conduct a study to determine if Medicaid reimbursement to physicians has changed as was promised by the 1992 Legislature and whether physicians actually recoup their license surcharge. The study would be conducted with the goal, if possible, of having its final results presented to the MMA Board of Trustees for review and possible action before the 1995 legislative session.

Res. 30, Clarification of the Term "Provider" in Advertising, Contracts, and Other Communications

Adopted as amended.

The MMA will develop and support legislation requiring that health care entities, when using the term "provider" in contracts, advertising, and other communications, specify the type of provider being referred to by using the provider's recognized title, which reflects education, training, license status, and other recognized qualifications. The MMA will submit a resolution to the AMA asking that legislation continue to be pursued that would call for the replacement of the current definition of physician in the federal law with the AMA's definition.

Sub. Res. 31, Data on Firearm Deaths and Injuries; Firearm Injury Prevention Task Force Study; Study on Number of Firearms in Schools

Adopted in lieu of Resolutions 31, 40, and 41. (See page 40.)

Res. 32, Standardized 2 Percent Provider Tax Reporting by Third-Party Payers

Adopted as amended.

Until the 2 percent provider tax is repealed, the MMA will continue to work through existing coalitions to develop a consistent format for reporting the 2 percent provider tax that will be used uniformly by all third-party payers when making payments to physicians and other health care providers.

Res. 33, Establishment of Peer Consultation Program to Assist Physicians in Disputes with Health Plans

Referred to the Board of Trustees for study.

Be it resolved that the MMA establish a peer consultation program to assist physicians involved in disputes with insurance companies or health plans regarding patient treatment decisions.

Res. 34, Student Loan Payment Deferment

Adopted.

The MMA will bring to the AMA a resolution supporting the creation of a deferment program for government-sponsored guaranteed student loans to delay repayment of such loans by medical students until one year after the completion of a residency program.

Res. 35, Repeal of $400 Physician License Surcharge

Adopted.

The MMA will restate its opposition to the $400 physician license surcharge and continue its efforts to gain its repeal at both the state and national levels.

Res. 36, Mandated Use of High-Efficiency Particulate Air Filter Masks (HEPA)

Adopted.

The MMA will work with the Minnesota Hospital Association to protest the current regulation on HEPA masks as an expensive and unproven safety measure until their efficacy can be proven with appropriate epidemiologic studies.

Res. 37, Radiological Technologists Certification

Adopted as amended.

The MMA will review its policy (HD-SR4-1981) regarding x-ray machine operators by convening an ad

Resolutions continued on page 44

Resolutions *continued from page 43*

hoc committee to study the issue and report to the MMA Board of Trustees.

In lieu of Res. 38, Sub. Res. 7 was adopted

Res. 39, Policy on Handguns and Automatic Repeating Weapons

Adopted as amended. (See page 40.)

Resolutions 40 and 41 were combined into Sub. Res. 31 and adopted

Sub. Res. 42, Public Education on Firearms in Homes; Educational Programs on Firearms

Adopted. (See page 40.)

Res. 43, Physician Educational Campaign on Patient Firearm Screening

Adopted as amended. (See page 40.)

Res. 44, Conflict Resolution Training

Adopted as amended. (See page 40.)

In lieu of Res. 45, Sub. Res. 42 was adopted

In lieu of Res. 46 and 47, Sub. Res. 7 was adopted

Res. 48, Geographic Equality in GAMC and Medicaid Reimbursement Rates

Adopted as amended.

The MMA will support and work aggressively for geographic equality in General Assistance Medical Care and Medicaid capitation rates to ensure continued appropriate access to all levels of care for all Minnesotans.

In lieu of Res. 49, Sub. Res. 7 was adopted

Res. 50, Gatekeepers in the Provision of Medical Care

Referred to the Board of Trustees for review and action.

Be it resolved that the MMA oppose denial of patients' access to a qualified physician by a limited-licensed practitioner gatekeeper.

Res. 51, Suspension or Removal of Members of the Minnesota Board of Medical Practice

Referred for study to the Board of Trustees.

Be it resolved that the MMA propose legislation that would provide processes for suspending and removing members from the Minnesota Board of Medical Practice.

Res. 52, Definitions Related to Principal Care

Referred to the Board of Trustees for study and action.

Be it resolved that the MMA adopt the Definitions of Principal Care [developed by the Minnesota Association of Neurologists] and that the Minnesota delegation carry this resolution to the AMA.

Res. 53, Data Definitions

Adopted as amended.

The MMA will work with the Minnesota Department of Health, the Minnesota Health Data Institute, and other appropriate groups to develop a glossary of terms related to collection and analysis of patient care data, with consistent and clinically meaningful definitions, and the MMA will submit a resolution to the AMA for development of a similar national glossary.

Res. 54, Retention of Allocated Funds within the Health Care System

Adopted as amended.

The MMA will develop and pursue legislation that will ensure that revenues that are received specifically to fund the MinnesotaCare program cannot be transferred or used for any other purpose.

Res. 55, Cooperation with Minnesota Medical Group Management (MMGMA) on Government Affairs

Not adopted.

This resolution calling for the MMA and MMGMA to work together in specific ways was not adopted because the MMA and MMGMA are already undertaking the activities called for in Resolution 55.

In lieu of Res. 56, Sub. Res. 7 was adopted

Res. 57, Support of Lawsuit Against Tobacco Industry

Adopted as amended.

The MMA will support the lawsuit brought by the state of Minnesota and Blue Cross/Blue Shield of Minnesota against the tobacco industry and will applaud them for their efforts toward reducing smoking and improving the health of Minnesota citizens. The Minnesota delegation to the AMA will submit a resolution asking the AMA to develop an amicus brief in support of lawsuits brought against the tobacco industry to reduce smoking and improve patient health and, in particular, support for the lawsuit brought by the state of Minnesota and Blue Cross/Blue Shield of Minnesota against the tobacco industry.

In lieu of Res 58 and 59, Sub. Res. 7 was adopted

The Monitor
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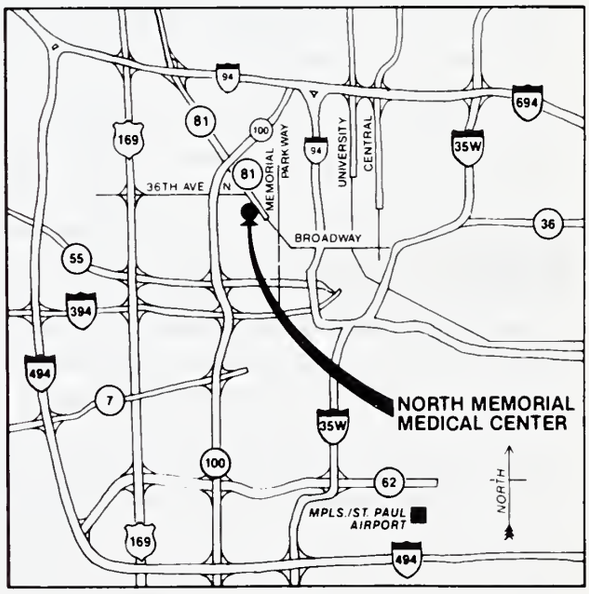

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Minnesota Medical Association Guaranteed Benefits Task Force Report

The MMA has proposed a set of standard health care benefits for all Minnesotans.

Janet Silversmith

The Minnesota Medical Association (MMA) convened a task force in 1990 to define a package of basic medical care. Specifically, the group was charged with defining a package of universal and equitable minimum medical care benefits. A central challenge to the group was to reconcile services across medical specialties and to define a package of medical benefits that would provide essential services to all individuals. To accomplish the objective, a variety of medical specialists from across Minnesota were invited to serve on the task force. Additionally, the group included business and labor representatives, consumers, insurers, and seniors. A final report of the task force, completed in February 1991, identified three categories of services—basic (part of the universal set of benefits), desirable (could be added to the universal benefits set if societal resources allowed inclusion), and optional (a service that should be left to the individual and not included in the universal benefits set). The 1991 report appears in the March 1991 issue of *Minnesota Medicine*.

During the fall of 1993, the Minnesota Medical Association readdressed the issue of a benefits set. Minnesota's health system reform called for the creation of a standard benefits set for use in the integrated service network (ISN) delivery system. The MMA reconvened many members from the 1990 task force and expanded participation to include other health care providers in an effort to review the original product and revise it given the changes in the health care market. This report reflects the work of the MMA Guaranteed Benefits Task Force.*

A Theoretical Approach to Benefits Set Creation

The need for a guaranteed benefits set

Most health system reform plans include a provision for a standard benefits package. The Clinton proposal, for example, would determine national benefits in statute, and these would then be interpreted and updated by a national health board. There are several reasons for the creation of a standard benefits package. Some of the reasons parallel those given for reforming the health care system—cost containment, quality, and access. Universal coverage is a critical component of health system reform and a provision that the MMA has long supported. Universal coverage, however, begs the question, "Coverage for what?" That is, should everyone have coverage for all available services, or should everyone have coverage for a defined, guaranteed, and standardized set of services? Universal coverage to unlimited services would result in cost increases, not cost containment. However, limiting coverage to specific services often invokes the fear of rationing. Many people contend that rationing exists in the current system—it is simply veiled in ability to pay.[1] Therefore, the development of a standard benefits set would not determine whether society rations care, since it currently is rationed in several ways; rather, a benefits set could create a rational method of allocating resources.[2]

Improved quality is another reason often cited for health system reform and benefits set creation. Quality improvement may be difficult to measure and compare; however, the creation of a standard set of services accomplishes two immediate goals. First, purchasing health care coverage would be greatly eased if a standard benefits set were available from all insurance companies; this would result in choices based on health plan efficiency or cost, rather than on nebulous benefits and hidden exclusions. Second, overall health status could be im-

* The terms basic benefits, universal benefits, standard benefits, and guaranteed benefits are often used interchangeably. The task force, however, agreed to use the term "guaranteed" when describing the set of services that the group would define. The intent of this language was to capture the idea that this benefits set is a guaranteed level of coverage for all individuals. It is not limited or basic services, but rather a set of services that is comprehensive enough in scope to serve as a floor of coverage for everyone. If someone were unable to purchase services above the package, the general health of an individual would not suffer as a consequence of having coverage limited to the guaranteed benefits set.

proved by guaranteeing a certain level of coverage for all individuals. Preventive services, for example, should be more readily attainable in the context of universal, guaranteed coverage for such services. It should be noted that the MMA task force recognized the existence of other access issues even in the face of universal coverage—geographic access and cultural and language barriers, for example. The task force concluded, however, that these non-financial barriers to care were beyond the scope of the group's charge.

The risk of adverse selection has also been identified when benefits are not standardized. If health plans can modify benefits, they will likely do so to attract low-risk enrollees and avoid those with higher risks. Health plans that vary benefits packages may end up driving out services that many sick people need most.[3]

A standard benefits package would guarantee equitable coverage for specific services, contribute to efforts to efficiently control costs, and allow direct, effective comparisons when purchasing health care coverage.

A benefits package for Minnesota

The 1993 Minnesota Legislature passed legislation that established the groundwork for the development of a new delivery system known as integrated service networks, or ISNs. This new system is fairly closely aligned with the tenets of managed competition. ISNs are envisioned as organizations that integrate health care delivery and insurance functions. ISNs will be accountable for the costs and outcomes associated with the delivery of care to their enrollees and will compete on that basis.

Although Minnesota does not require employers to offer health insurance coverage to their employees, it does regulate the contents of some of the health plans that may be offered.[4] In an effort to consolidate some of this activity and create a standardized approach to benefits regulation, the 1993 legislation called for the creation of not more than five standardized benefits plans for use by ISNs. The five plans could only differ on the basis of enrollee cost-sharing.[5] In essence, the Legislature recognized the utility of one standard package of services for the ISN system to allow competition to occur on the basis of cost and quality and not on the basis of benefits modification. The 1993 Legislature called for the development of a benefits package that would provide "appropriate and necessary" health services. This language was clarified to mean services that are needed to maintain the enrollee in good health, including as a minimum, but not limited to, emergency care, inpatient hospital and physician care, outpatient health services, and preventive health services.[6]

The 1994 Legislature deleted all language related to basic benefits found in the 1993 law. The approach taken by the 1994 Legislature was to call for the creation of a report on covered services containing the recommendations of the Minnesota Departments of Health, Commerce, and Human Services, the Minnesota Health Care Commission, as well as the recommendations of an advisory committee of providers, purchasers, consumers, and health plans. Again, the Legislature called for the creation of up to five standard benefits sets that contain all appropriate and necessary health care services and differ only on the basis of enrollee cost-sharing. Specific consideration for inclusion in the benefits set is to be given to benefits necessary to meet public health goals, benefits that adequately serve high-risk and special-needs populations, benefits that facilitate the utilization of cost-effective alternatives to traditional inpatient acute and extended health care delivery, or benefits that meet other objectives of health system reform.[7] Appropriate and necessary dental services, which are to be defined by a dental advisory task force, are explicitly mentioned as included services.

The report that the Legislature requested (due January 1, 1995) is to include a definition for appropriate and necessary care in terms of type, frequency, level, setting, and duration of services that address the enrollee's mental and physical condition. The Legislature established a preference for a comprehensive benefits set when it acknowledged the fact that a benefits set that excludes genuinely appropriate and necessary services will not reduce or contain costs, but will only transfer those costs onto individuals and the public sector; therefore, the Legislature noted, the definition of appropriate and necessary care must be sufficiently broad to address the needs of those with chronic conditions or disabilities, including those who need health services to improve their functioning, those for whom maintenance of health may not be possible, and those for whom preventing deterioration in their health conditions might not be achievable.[8]

Defining a guaranteed benefits set

It is far easier to produce agreement that a benefits set must be developed than it is to define the actual services that should be included. Developing a benefits set raises significant philosophical and ethical issues. There is often disagreement over the theoretical approach to take in defining a benefits package. Many people believe that it is most important to create an affordable benefits set, which is often translated into some kind of catastrophic coverage plan. Others, however, contend that true cost containment can best be accomplished if the benefits package contains a comprehensive set of services. In this way, costs subject to global budgets or growth limits can easily be tracked, and less cost-shifting is likely to occur if the benefits package contains a broad range of services. Paul Ellwood, president of the Jackson Hole Group, which articulated the managed competition approach to health care reform, believes that a comprehensive benefits package that includes preventive care is absolutely necessary if health care costs are to be controlled.[9]

The MMA task force took a clear position on this issue at the outset when it agreed to develop a comprehensive benefits set. Business representatives expressed concern, cautioning that an affordable package would be critical to business acceptance of the plan. The task force did not debate how the benefits set should be linked to specific cost-control efforts, i.e., applying the growth limits only to services in the benefits set or applying

growth limits to all health care services delivered.

Two dominant approaches exist for framing the services within a benefits set. One approach would specify what services or conditions will be covered, such as heart transplants or physical therapy; the other approach would define coverage for broad categories of care, such as outpatient or hospital services, and allow, for example, health plans or communities to define the specific services covered within the broad parameters.[10] Proponents of the specific services approach argue that identifying specific services to be covered would put health care spending into context; there is also the fear that without identifying specific services, too much is left to the discretion of health plans or other administering units. Opponents of the specific services approach (and proponents of the broad categories approach) argue that to cut spending effectively, we need to curb the frequency of all services based on their medical benefit, rather than eliminate certain services.[10]

The task force decided that identifying specific services would result in the most standardization of benefits. Nevertheless, because it is difficult to define every specific service, some latitude is appropriate. The task force did not address issues related to the actual administration of the benefits set, such as the use of gatekeepers and referrals, concluding that such issues were generally best left up to the health plans or ISNs.

Clinical, ethical, and political considerations

Given the task force position on defining specific services for inclusion in a comprehensive, guaranteed benefits package, the issue of determining whether a particular service should be included becomes very complicated and can involve clinical, political, and ethical considerations. Ideally, identification of benefits for inclusion in a standard package would be based on scientific evidence of clinical efficacy and cost-effectiveness. In reality, however, benefit determination is a combination of all three factors—ethical, political, and clinical.

Some procedures have been clinically proven to be both efficacious and cost-effective, and some have been proven unnecessary. There are far more services for which results are lacking. A recent report from the U.S. Office of Technology Assessment concluded that many preventive services, often viewed as important "investments" in health care coverage, have never been evaluated for efficacy or cost-effectiveness.[11] In addition, the report concluded, only a few of the services that have been evaluated are actually effective *and* result in a reduction of medical care costs to society; examples of services that meet both tests include most childhood immunizations, newborn screening for some congenital disorders, and prenatal care for poor women.[11]

One approach to defining benefits is to distinguish necessary from unnecessary services based on medical practice guidelines. Proponents of this approach encourage the development of practice guidelines for every health care service to determine the clinical conditions in which care is considered necessary. The guidelines would then serve as the standard benefits; services that meet the guidelines for necessary care would be included, and services that do not meet the guidelines' determination of necessity would be excluded. Although numerous groups, such as professional associations and health plans, have developed guidelines for necessary care, there are far too few universally accepted guidelines currently developed upon which a benefits package could be created.

At an April 1993 meeting of the Institute of Medicine, significant time was devoted to defining medical necessity and arguing whether the data exist to make objective determinations of which medical services to cover.[1] As medical ethicist Daniel Callahan explains, "It seems clear enough that there is neither now nor ever likely to be some simple, utterly clear, purely medical standard of 'need' such that a basic set of benefits could be developed out of that objective knowledge alone. ... So to solve the problem ... we turn to a political process, recognizing not only the need to consider things other than need, but also because we understand that they will all remain contestable."[12]

The political process is often viewed as an imperfect site for the debate on benefits set design, despite its open forum for discussion. The primary reason for the concern is the potential for intense lobbying by a multitude of interest groups seeking to obtain coverage for their own cause. The experience most states have had with mandated benefits is another reason cited for skepticism concerning the political process. It is unlikely, however, that the public and various constituent groups would want Congress or state legislatures to forfeit decisions on benefits set determination.

Ethical implications are inherent in benefits set determinations. The central issue may be how or whether social judgments and values will or can be included.[13] Numerous questions emerge. What is equitable coverage? Whose values do you use to make coverage decisions? How do you balance the needs of the individual with those of society?[1] (See related article, page 25.) Additionally, concerns about the prospect of rationing care emerge, as previously discussed. A late-1992 Gallup survey commissioned by the Employee Benefit Research Institute yielded several interesting results concerning what society may accept in the design of a benefits set:

- 86 percent of respondents found it unacceptable to reduce the amount of health care currently available to the elderly;
- 66 percent opposed limiting types of services to low-income individuals;
- 61 percent opposed limiting types of services health plans will cover;
- 57 percent said it was unacceptable to limit the introduction of new, expensive, high-technology equipment that saves lives but may increase costs.[14] (For the results of a similar Minnesota survey, see page 19.)

A final issue to be considered in defining a benefits set is affordability. Two basic approaches exist for factoring cost into benefits set design. One approach would tie covered services to available resources. An alternative approach would separate decisions about the content of the benefits package from resource allocation decisions.

Ultimately, coverage and resources would need to be reconciled; however, at what point financial considerations enter the decision-making process is an important issue that should be resolved up-front.

The MMA task force recognized the importance of affordability but decided to identify covered services and resolve issues of cost at a later time. The task force did, however, make some determination of affordability when deciding service limitations; for example, it initially considered use of copays and deductibles, limits on the number of services or dollars available for a service, or coverage for services only when linked to a specific diagnosis. A complete description of the process the task force used is included in the Methodology section of this report.

Methodology

Task force charge and assumptions

The MMA Guaranteed Benefits Task Force accepted the following charge: to develop a guaranteed, standardized benefits set upon review and consideration of the American Medical Association's (AMA) proposed benefits set, the Clinton proposal for a guaranteed benefits package, and the medical benefits set defined in the 1991 report of the MMA Medical Benefits Task Force. The task force further clarified the charge by adopting the following principles:

• The benefits set produced will be a guaranteed floor of services below which no individual will fall.

• The benefits set will be comprehensive in scope, rather than a catastrophic coverage plan, to ensure an adequate level of health care coverage for all individuals.

• The services identified for inclusion in the benefits set will be specifically defined (as opposed to broad categories) to achieve a high level of standardization of benefits.

• The guaranteed benefits set should be universally applied across delivery systems, i.e., the same benefits set should apply to the ISN, regulated all-payer option (RAPO), and private- and public-sector programs.

• Medical care is only one component of a broader spectrum of interventions that affect health. The composition of a benefits set can best be defined using health care terminology. The administration and delivery of the guaranteed benefits set may vary given the conditions of the community and the resources of the health plan.

• The affordability of a benefits set is an important and complex issue that must be considered at the individual service level and at the aggregate societal level.

Given the charge, the task force found it helpful to identify some general assumptions that describe Minnesota's health care environment—the environment in which decisions about the benefits package will be made. Many of these assumptions were accepted in the 1991 report and still hold true. The overall theme in the following assumptions is resource constraints and resource allocation:

• Health care is a significant component of the Minnesota economy, and reform efforts should be cognizant of the potential economic impact. Although health care plays a significant role in Minnesota's economy, there are limits to society's willingness to expend additional resources for health care delivery. Consumers and providers need more information and need to be more sensitive to the actual costs of providing health care in order to understand the limited nature of resources.

• Achieving universal coverage to a guaranteed benefits set will not occur instantly. Some Minnesotans will, at least in the short-run, remain either uninsured or under-insured. As long as there are uninsured and under-insured individuals in the health care system, cost-shifting is likely to occur and should be anticipated; however, the goal should continue to be universal coverage using the guaranteed benefits set.

• Minnesota has the physical and financial resources, albeit limited, to provide high-quality health care, as continually evidenced by the state's comparatively high level of health status.

• Minnesota has a tradition and environment supportive of health initiatives and has strong managed care experience in several areas of the state. Managed care is expanding and will continue to grow in popularity as reform efforts continue.

• Managed care is not uniformly distributed throughout the state, partially because many rural areas have historically faced difficulties in recruiting and retaining health care providers. Rural areas and some urban pockets have and will continue to have significant need for health care providers.

• Recruitment and retention of providers is often linked to the composition of a provider's caseload. The ability of a provider's practice to succeed financially is directly linked to the payers of his or her caseload. There is general concern with the financing, reimbursement, participation, and access of some of the government-run programs, such as Medical Assistance, GAMC, and MinnesotaCare.

Values

Members of the task force brought a wide variety of opinions and perspectives to the process; however, the group agreed to accept and recognize a set of shared values for the development of the benefits package. In addition, the task force recognized the unique role that the benefits set plays in the context of health system reform. This recognition resulted in the creation of two sets of ranked values—one set that reflects an approach to general health system reform, and one set that specifically serves as criteria for the inclusion of specific services in the benefits set.

The task force recognized the following general health system reform values:

Universal coverage—and the sub-values related to achieving universal coverage and access to an equitably defined standard benefits set, including universality, accessibility, and equity.

Accountability—and the sub-values related to producing a health system that is accountable to patients and to society, including effectiveness, individual responsi-

bility, efficiency, and satisfaction.

Autonomy—and the sub-values related to preserving and enhancing freedom and flexibility in system design, in provider practice, and in relationships between providers and patients, including individual patient choice, continuity of care, and patient advocacy (by physicians).

Innovation/improvement—and the sub-values related to the advancement of medical education, research, disease diagnosis, and disease treatment, including information/research and use of the scientific method.

The task force recognized the following benefits set creation values and criteria for coverage:

Health promotion, disease detection, health education: Services for inclusion in a benefits set should promote health, detect disease, and encourage efforts to provide health education.

Relief of suffering: Services for inclusion in a benefits set should minimize the degree of suffering of an individual and the community.

Effectiveness: Services for inclusion in a benefits set should be included based on their proven ability to help patients.

Affordability: Services for inclusion in a benefits set should be cost-effective, and the aggregate cost of services should be affordable.

Community health: Services for inclusion in a benefits set should maximize the health status of the community under a universal coverage approach. Each health plan is to maximize the health status of the enrolled population. Within this structure, each patient will be given care to ensure as healthy a life as possible.

Limitation of disability: Services for inclusion in a benefits set should stabilize or decrease the disabling effects of disease.

Preservation of life: Services for inclusion in a benefits set should seek to preserve life; however, given the ranking of the task force, this value is not necessarily to be achieved at any cost.

Benefits selection process

The task force followed a six-step process to determine which services would be included in the recommended guaranteed benefits package.

1. Development: The task force developed a comprehensive list of services based on the contents of four sources—the 1991 MMA Medical Benefits Set, Clinton's proposed benefits package (as of fall 1993), the AMA's proposed benefits set, and the Minnesota Department of Health's proposed services in the integrated service network (ISN) implementation plan. This comprehensive list covered 383 services, which included most of the specific state mandates.

2. Refinement: The task force spent considerable time consolidating the various services to eliminate duplication, renaming services to allow reasonable comparison between service categories, and reaching consensus on definitions. This step resulted in a finalized list of 160 services.

3. Ballot No. 1: The approved list of 160 services was distributed to task force members for a vote. Preferences were cast on each service for inclusion in the guaranteed benefits set and on any limitations that may be applied. Services were deemed to be included in the benefits set if they received the vote of two-thirds of the voting task force members.

4. Ballot No. 2: The task force reviewed the results of the initial voting process and identified 35 services that were problematic for many task force members for a number of reasons. The 35 services were separated from the main list and were distributed for a re-vote.

5. Adjustment: The task force reviewed the final results of the balloting process and discussed the ranking of the services. Upon consensus of the group, final adjustments were made to some services, and the limitations were revised to reflect only those services that should have no financial limits placed upon them. General rules, rather than particular suggestions, were adopted for the imposition of either dollar or number caps or copays and deductibles.

6. Adoption: The task force adopted the finalized list of services as the recommended contents of the MMA guaranteed benefits package.

During the balloting process, task force members were asked to choose one of the following inclusion preferences for each service:

- Yes: The service must be included in the definition of a guaranteed benefits package. It does not necessarily mean that the service would be available without limitation.
- Yes, but for low-income only: The service should be included as a standard benefit for low-income individuals. That is, it should be provided universally only to those who would otherwise be unable to pay for it. These services may be considered supplemental services. They are not required for all individuals in the guaranteed benefits set, but must be guaranteed for low-income persons.
- No: The service should not be included in a standard, guaranteed benefits set; that is, it is a service that all individuals should have to pay for separately, and it is a service that should not be subsidized to ensure availability to all.

Critical to the balloting process was the overriding assumption that all services included in the guaranteed benefits set would only be provided when "medically necessary." That is, the services would be performed within the context of existing and evolving community standards and community utilization review processes. Medically necessary implies that a diagnosis has been or is being determined. Although the term medical necessity creates significant debate about how to best apply a definition, the task force wanted to articulate the belief that services would only be delivered when deemed necessary by a health care provider acting within his or her scope of practice. The application and determination of medical necessity is certain to be controversial to a provider and patient at some point in time. It is important that providers and patients have the opportunity to appeal such determinations.

As mentioned, inclusion of a service within the

guaranteed benefits set does not mean unlimited utilization. As a group, the primary recommendations about cost and utilization focused on the appropriateness of various types of limitations for each identified service. Individual members were initially asked to choose one or more limits for each service that they selected for inclusion in the benefits set. Limits could be one or more of the following:

- Dollar or number limit: The service could be limited to a specific number of visits or by some amount of money spent on it for a particular time period.
- Copay/deductible: The service could be limited by the use of an enrollee copay and/or deductible.
- Diagnosis: The service could be limited only when used in conjunction with a particular diagnosis.

The opinion of the task force on the issue of limitations was centered on the question of whether or not any of the three possible limits were appropriate for a particular service; there was no attempt to quantify the degree of the limitation. Studies have shown that the use of cost-sharing mechanisms reduces overall costs and utilization by as much as 25 percent.[15] The construction of a copayment or other type of limitation plan must be done very carefully. Copayments have been found to decrease utilization of care for both minor and serious symptoms.[16] The use of a copayment program to limit utilization and control cost may result in cost increases if consumer behavior is perverted by the use of excessive or misapplied cost-sharing techniques.

During final review, the task force concluded that the application of specific limitations was often arbitrary. In an attempt to reconcile the group's belief that limitations were often appropriate and necessary for many services and the fact that many felt uncomfortable applying limitations without sufficient information, the group decided to identify services that should be available without any financial limitations. That is, the group concluded that there was significant benefit in aggressively seeking utilization of these services. In addition, the group developed standards for the application of caps or copays/deductibles that could be applied, assuming that appropriate access would not be limited.

The group agreed that the theory of the law of diminishing returns should be applied to caps, either number or dollar. That is, the maximum benefit is often derived from the first visit, service, or treatment. At some point, the marginal benefit of an additional visit, service, or treatment is diminished, and additional utilization yields minimum benefit. Hospitalization is a good example. The first day following surgery is critical to improvement; however, the advantage of staying for five days for a particular procedure may do little to improve the patient's health.

Copays and/or deductibles were determined to be appropriate for services that could be limited up-front using the general principles of elasticity of demand. A change in the "price" of a service (an additional copay) yields some change in quantity "consumed." Elastic demand implies that a price increase reduces utilization or consumption. Copay systems that seek to change utilization patterns will, therefore, be most effective when applied to services with elastic demand curves. The concern, of course, is designing a copay system that does not reduce utilization beyond appropriate limits. For conditions that are likely to improve without intervention or for those that are likely not to worsen or create an adverse health outcome, the group concluded that a copay is appropriate. Copays are often used for cost-sharing purposes in addition to utilization control. Pharmaceutical copays are generally used for cost-sharing purposes. The use of co-pays for non-emergency outpatient visits is primarily a utilization control measure. A patient with a headache, for example, may decide to see if the headache subsides without a visit to the health care provider if there is a nominal copay for an office visit.

Results

Task force recommendations

From an original collection of 383 services, the task force created a ballot of 160 services for potential inclusion in the guaranteed benefits set; 126 services were ultimately approved by the task force for inclusion in the guaranteed benefits package. Table 1 (pages 53-56) displays the services included in the final package—a set of proposed guaranteed services for every Minnesotan.

Among the services that were not adopted by the task force were some long-term care services, acupuncture, experimental treatments, specialized fertility treatments, reversal of sterilization, penile implants, cosmetic surgery, pancreas transplants, and transsexual surgery. It should be noted that long-term care services were not necessarily excluded from the list because they were deemed unworthy of inclusion; rather, the inclusion of long-term care services, at this time, represented a significant paradigm shift in how such services are covered, and the vote of the task force was more a reflection of a societal attitude than a dismissal of such services as inappropriate. The issue of long-term care services deserves continued discussion and review; the MMA will continue to monitor and analyze long-term care and will work to develop a well-informed recommendation.

Services that the group felt should be available without financial limit are identified in Table 1 by an "X" in the "No Limits" column. All other services may have limitations of some type applied to them; however, because those decisions are very complex, the task force offered guidelines for the application of caps and copays as an alternative approach, as discussed above.

Table 2 (page 56) identifies those services that the task force concluded were to be guaranteed to low-income individuals. The table is not a complete listing of services for low-income populations, but rather a list of services that, at a minimum, must be included for low-income populations *in addition* to the guaranteed benefits set provided to all individuals.

A comparison with other benefits sets

It is helpful to compare the services included in the MMA's benefits set with other existing benefits sets to

provide a context for the MMA's recommendations. One of the most well-known benefits sets is Oregon's package of services for the state's Medicaid population. For a brief review, see the sidebar on page 30. An alternative benefits set and often-cited package is the benefits set for Minnesota HMOs. The task force carefully reviewed the covered services in the HMO Act and compared them with the MMA guaranteed benefits set. A copy of this analysis is available in the full report of the task force. For a copy of the full report, please contact Colleen Jensen at the MMA, 612/378-1875.

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Table 1
Guaranteed benefits set

Services	No Limits
Access services: language translation	
Access services: medical transportation services (e.g., Medikabs)	
Access services: non-emergency ambulance transport services	
Ambulance services: emergency	
Blood and blood derivatives	
Chemical dependency: inpatient	
Chemical dependency: inpatient detoxification services	
Chemical dependency: outpatient	
Chemical dependency: residential (halfway house)	
Chiropractic treatment and evaluation for neuro-musculoskeletal conditions	
Dental: child preventive	x
Dental: child treatment	
Dental: injury treatment	
Dialysis: acute	
Dialysis: chronic (end stage renal disease)*	
Dietary treatment: other metabolic conditions	
Dietary treatment: phenylketonuria (PKU)*	
Diethylstilbestrol (DES)-related conditions*	
Emergency care: 24-hour hospital or freestanding facility	
Eye care: adult routine eye and vision exams	
Eye care: child routine eye and vision exams	
Eye care: eyeglasses for children	
Eye care: treatment of eye conditions	
Eye care: visual exams for symptoms	
Family planning: contraceptives	
Family planning: counseling and education services	
Family planning: elective abortion	
Family planning: fertility treatment, basic	
Family planning: pre-conception care	
Family planning: sterilization	
Genetic counseling	
Health education: behavioral risks/healthy lifestyles	
Health education: chronic conditions	

continued

Table 1 continued

	No Limits
Health education: nutritional counseling	
Health education: smoking cessation	
Health education: stress management	
Health education: system utilization	
Hearing: child routine hearing exams	
Hearing: exams for symptoms	
Hearing: hearing aids for children	
Hearing: treatment of hearing conditions	
Home care: for diagnosed medical condition and rehabilitation	
Home care: nursing services	
Hospice care: home health aide	
Hospice care: home-based	
Hospice care: hospital-based	
Hospice care: inpatient—hospice residence-based	
Hospital services: inpatient—anesthesia services	
Hospital services: inpatient—diagnostic services (including lab, radiology, and neurology)	
Hospital services: inpatient—nursing services	
Hospital services: inpatient—other professional services	
Hospital services: inpatient—physician medical and surgical professional services	
Hospital services: inpatient—private room when medically necessary	
Hospital services: inpatient—semi-private room and board	
Hospital services: inpatient—supplies	
Immunizations (adult and child)	x
Implants: artificial hips	
Implants: artificial joints other than hips	
Implants: cochlear	
Implants: intraocular lenses	
Implants: pacemakers	
Inhalation services: communicator/interpreter services for ventilator-dependent person (120 hours)*	
Inhalation services: oxygen and medications	
Inhalation therapy and evaluation	
Medical equipment: durable	
Medical equipment: prescription orthotics (i.e., braces)	
Medical equipment: prostheses	
Medical equipment: prosthetic device training	
Medical equipment: syringes/chemstrips	

	No Limits
Mental illness/psychiatric disorders: acute residential care—adult	
Mental illness/psychiatric disorders: acute residential treatment—adult	
Mental illness/psychiatric disorders: chronic residential treatment—adult	
Mental illness/psychiatric disorders: crisis intervention services	
Mental illness/psychiatric disorders: inpatient	
Mental illness/psychiatric disorders: inpatient professional services	
Mental illness/psychiatric disorders: outpatient professional services	
Mental illness/psychiatric disorders: outpatient—group therapy	
Mental illness/psychiatric disorders: outpatient—individual therapy	
Mental illness/psychiatric disorders: partial hospitalization/day treatment	
Mental illness/psychiatric disorders: residential treatment facility care for emotionally handicapped children*	
Nuclear medicine: diagnostic isotope scanning	
Nuclear medicine: isotope therapy (i.e., thyroid)	
Nursing home care: short-term rehabilitation (less than 90 days)	
Obesity treatment: education/counseling	
Obstetrical care: delivery services	
Obstetrical care: inpatient services—complication of pregnancy with no delivery	
Obstetrical care: inpatient services—normal and caesarean births	
Obstetrical care: obstetrical services of physicians and other professionals	
Obstetrical care: outpatient maternity non-delivery procedures (miscarriages, therapeutic abortions)	
Obstetrical care: postnatal care	
Obstetrical care: postnatal health education	
Obstetrical care: prenatal care (including education)	x
Occupational therapy and evaluation	
Outpatient services: allergy tests and injections**	
Outpatient services: anesthesia services**	
Outpatient services: diagnostic services (including lab, radiology, and neurology)**	
Outpatient services: nursing services**	
Outpatient services: other professional services**	
Outpatient services: physician medical and surgical professional services**	
Outpatient services: second surgical opinions—elective**	
Periodic health evaluations (including screenings)—per national standards	
Pharmaceuticals: prescription drugs, biological products, insulin, equipment, and supplies	
Physical therapy and evaluation	
Plastic surgical services: cleft lip treatment*	

continued

Table 1 continued

	No Limits
Plastic surgical services: cleft palate treatment*	
Plastic surgical services: correction of functional disorder—congenital abnormality	
Plastic surgical services: correction of functional disorder—injury or incidental to covered surgery	
Plastic surgical services: craniomandibular disorder*	
Plastic surgical services: reconstructive surgery due to injury, sickness, or other diseases*	
Plastic surgical services: reconstructive surgery following mastectomy	
Port-wine stain elimination*	
Psychiatric/psychological evaluations	
Respiratory therapy and evaluation	
Speech therapy and evaluation	
Temporomandibular joint disorder (TMJ) treatment*	
Transplants: bone marrow	
Transplants: cornea	
Transplants: heart	
Transplants: heart/lung	
Transplants: kidney	
Transplants: liver	
Transplants: lung	
Transplants: musculoskeletal (bone)	
Transplants (re-implantation): parathyroid	
Urgent care—non-emergency after-hours care	
Well-child care (including preventive checkups and immunizations)	x

*Mandated state or federal benefit.

**The outpatient services category is intended to include a variety of settings, including office, nursing home, and home visits.

Table 2

Guaranteed services for low-income population

Services
Access services: child care
Access services: public or private transportation services
Eye care: eyeglasses for adults
Hearing: hearing aids for adults
Home care: social services

Educating Your Patients About Health Records—The New Notice Law

Providers should be ready to answer patients' questions about who has access to their health records.

Michelle M. Boynton, J.D., and Jean Paltzer-Fleming, M.D., J.D.

A new law may lead more patients to ask just who has access to their medical records. The law, which was enacted by the 1994 Minnesota Legislature and went into effect July 1, 1994, requires providers to furnish patients with a written notice about who can gain access to information in their health records.[1] This notice must include an explanation of patients' rights to gain access to and obtain copies of their health records and the types of health records that may be disclosed without patient consent and to whom these records may be disclosed. The notice may be included with the patient and resident bill of rights or displayed prominently in the provider's place of business.

The commissioner of health has developed a notice providers can make available to patients (see page 62); it will be published in an upcoming Minnesota *State Register*. The commissioner's notice is brief and is likely to raise questions in the minds of both providers and patients about when patients and third parties may gain access to health records. This article is intended to answer some of those questions. First, we discuss when patients may gain access to their health records. Second, we highlight some of the most common situations in which health records may be released to third parties without patient consent.

Releasing Health Records to Patients

As a general rule, providers must allow patients to review and obtain copies of their health records whenever requested. Minnesota law states that a provider must furnish a patient with "complete and current information possessed by that provider concerning any diagnosis, treatment, and prognosis of the patient in terms and language the patient can reasonably be expected to understand."[2] If a patient requests copies of certain health records, the provider must furnish copies to the patient, including copies of any laboratory reports, x-rays, prescriptions, and other technical information used in assessing the patient's health condition. Providers may charge patients a reasonable fee (as described in Minnesota law) for the copies, unless the copies are requested for the purpose of reviewing current medical care. If the patient agrees, the provider may furnish the patient with a summary of the patient's health records instead of copies of the records.

A provider may withhold health record information from a patient in two situations. First, a provider may exclude from the health record "written speculations about the patient's health condition" (although all information necessary for the patient's informed consent to contemplated treatment must be included). Second, some providers may withhold information from a patient if the provider "reasonably determines that the information is detrimental to the physical or mental health of the patient, or is likely to cause the patient to inflict self harm, or to harm another." In such cases, the provider may supply the information to an appropriate third party or to another provider, who may then release the information to the patient. If, however, the provider is a health care facility, information from the health record may only be withheld from the patient if "a specific basis for withholding the information" has been designated and described before the patient requests the information.

Releasing Records to Third Parties Without Consent

As a general rule, information from a patient's health records cannot be released to a third party without the patient's prior written consent. There are, however, numerous exceptions to this general rule. Following is a brief overview of some of the most common situations in which health record information may be released to third parties without patient consent. The overview, which addresses Minnesota statutory and administrative law only, is divided into two main sections: 1) situations in which a provider may voluntarily release patient health record information; and 2) situations in which a provider is required to release patient health record information.

The laws regulating the release of

health record information are broad and complex and are subject to change any time. This article does not discuss federal laws related to release of health record information (such as federal laws regulating the release of alcohol or drug abuse information) which could pre-empt state laws. To avoid liability for illegally releasing health records, providers should consult legal counsel if they have any questions. In addition, providers should only release information from the health record that is allowed or required and should rarely (if ever) release the entire health record.

Voluntary release without patient consent

Emergency: Health record information may be released without patient consent in a medical emergency. According to Minnesota law, if a provider is unable to obtain the patient's consent because of the patient's condition or the nature of the medical emergency, then the patient's health records may be released without the patient's consent.[3]

Health threat: A licensed health professional or other human service professional may voluntarily file a report with the commissioner of health if the professional has "knowledge or reasonable cause to believe" that a person who is a carrier of a potentially infectious disease is a health threat to others.[4] A carrier may be considered a health threat to others if the carrier "demonstrates an inability or unwillingness to act in such a manner as to not place others at risk of exposure to infection that causes serious illness, serious disability, or death."[5] If the commissioner agrees that the carrier is a health threat to others, the commissioner may issue a health directive to the carrier. The directive may require the carrier to participate in education, counseling, and treatment programs and may require the carrier to cooperate with health authorities in preventing transmission of the disease. If a professional has knowledge or reasonable cause to believe that a carrier has failed to comply with a written directive, the professional may also report this information to the commissioner of health. Because the information reported could be very sensitive, professionals should be certain that reports are made in compliance with the law.

Immunization data: Patient consent may not be required to release immunization information. State law says that a provider may exchange immunization data with other providers, child care facilities, elementary schools, secondary schools, post-secondary schools, boards of health, community action agencies, and the commissioner of health without patient consent, provided the party requesting the information delivers services to the patient. The provider may release information regarding the type of immunization administered to the patient and the date it was administered.[6]

Driving ability: If a patient has a physical or mental condition that could significantly impair his or her ability to operate a motor vehicle, the physician may voluntarily report information about the patient to the commissioner of public safety.[7]

Medical or scientific research: Until June 1, 1996, health records may be released without the patient's consent for limited research purposes.[8] The records may be released to qualified personnel for the sole purpose of medical or scientific research. The provider must assure that the confidentiality of the records will be protected by making "a reasonable effort to determine that: (i) the use or disclosure does not violate any limitations under which the record was collected; (ii) the use or disclosure in individually identifiable form is necessary to accomplish the research or statistical purpose for which the use or disclosure is to be made; (iii) the recipient has established and maintains adequate safeguards to protect the records from unauthorized disclosure, including a procedure for removal or destruction of information that identifies the patient; and (iv) further use or release of the records in individually identifiable form to a person other than the patient without the patient's consent is prohibited." Finally, the records can only be released without consent if the patient has not objected to a release of the records for research purposes.

Commissioner of health/Data Institute: Information from health records may be released to the commissioner of health or the Minnesota Health Data Institute as part of the data collection efforts under MinnesotaCare, as long as the commissioner encrypts the patient identifier upon receipt of the data.[9] At this time, the commissioner of health does not plan to collect encounter-level data from physicians under Chapter 62J of MinnesotaCare. Instead, the commissioner plans to collect this data from third-party payers.

Independent medical exams: A provider does not need to obtain a patient's consent to release health records created as part of an independent medical examination if the records are being released to the third party who requested or paid for the examination.[10]

Child abuse/vulnerable adult abuse/victim warning: As discussed below, most providers have a mandatory duty to report suspected neglect or abuse of children or vulnerable adults, and certain health care professionals other than physicians have a mandatory duty to warn potential victims against a violent patient. The laws regulating these mandatory reports also include provisions that allow voluntary reporting by providers and other persons in certain circumstances.[11-13]

Mandatory releases

Child abuse or neglect: Health care professionals and delegates of professionals have a mandatory duty to report child abuse or neglect.† The duty applies when the professional or delegate "knows or has reason to believe" that a child is being neglected, sexually abused, physically abused, or mentally abused, or has been neglected or abused within the preceding three years. An oral report

†Minnesota Statutes, Section 626.556, subdivision 3(a)(1) (1994) states that the mandatory child abuse/neglect reporting duty applies to "a professional or delegate who is engaged in the practice of healing arts, social services, hospital administration, psychological or psychiatric treatment, child care, education, or law enforcement."

must be made as soon as possible, and no later than 24 hours after the suspected abuse or neglect is discovered. A written report must follow the oral report within 72 hours. The report must identify the child, any person believed to be responsible for the abuse or neglect of the child (if known), the nature and extent of the abuse or neglect, and the name and address of the person filing the report. The report must be made to the local welfare agency, police department, or county sheriff. If the child has died and there is reason to believe that the death resulted from the abuse or neglect, then the information must instead be reported to the appropriate medical examiner or coroner.

Prenatal exposure to controlled substances: Health care professionals and their delegates† have a mandatory duty to file a report with the local welfare agency if the reporter "knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during pregnancy."[14] An oral report must be made immediately, and a written report must follow within 72 hours. The report must identify the pregnant woman, the nature and extent of controlled substance use (if known), and the name of the person filing the report.

Vulnerable adult abuse or neglect: Health care professionals and other persons providing services to vulnerable adults (as defined in Minnesota law) have a mandatory duty to report the abuse or neglect of a vulnerable adult.[15] The duty to report arises whenever the provider has "knowledge of the abuse or neglect of a vulnerable adult, has reasonable cause to believe that a vulnerable adult is being or has been abused or neglected, or has knowledge that a vulnerable adult has sustained a physical injury that is not reasonably explained by the history of injuries." An oral report must be made to the local police department, county sheriff, local welfare agency, or appropriate licensing or certifying agency as soon as possible and must be followed by a written report. The report must identify the vulnerable adult, the caretaker, the nature and extent of the suspected abuse or neglect, any evidence of previous abuse or neglect, the name and address of the person filing the report, and any other information that may be helpful in investigating the report.

Workers' compensation: When treating a patient for a workers' compensation claim, certain health care providers must supply the insurer with information from the patient's medical records that substantiates the charges and necessity of the service provided.[16] This information must be furnished to the insurer when the provider submits a bill for the services. Upon request, the provider must also supply medical data regarding the claim to the Department of Labor and Industry, as well as to the employee, employer, and insurer who are parties to the claim. Only medical data that are directly related to the current injury or disability should be provided.

Warning of violent behavior: State law places a duty on psychologists, school psychologists, nurses, chemical dependency counselors, and social workers who perform psychotherapy to warn potential victims if a patient has "communicated to the practitioner a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim."[17,‡] In such a case, the practitioner must make a "reasonable effort" to communicate the threat to the potential victim. This duty to warn does not apply if the patient threatens to harm himself, or if the patient making the threat has been adjudicated mentally ill and dangerous under Minnesota law.

Occupational diseases: To aid in the investigation and control of occupational diseases, physicians treating individuals with employment-related maladies are required to report certain information about the patient, the patient's employer, and the patient's condition to the Health Department within five days. Minnesota law requires the department to furnish physicians with suitable forms to assist with compliance.[18] Physicians are also required to report similar information to the Department of Labor and Industry.

Communicable diseases: Physicians, other licensed health care providers, health care facilities, and medical laboratories that receive specimens from patients are required to report to the commissioner of health "cases, suspected cases, carriers, or deaths" from any of a long list of communicable diseases.[19] Generally, reports must be made within one working day, although immediate telephone reports are required for certain diseases. Reports must contain information including, but not limited to, the disease, the patient's name and address, the patient's place of employment, and the name and locating information of contacts, if any. Individuals with knowledge of an unusual incidence of disease that may indicate an outbreak or epidemic must report the information to the commissioner. Finally, cases, suspected cases, carriers, or deaths due to diseases that may have been acquired outside the state and that are rare in Minnesota or are a public health problem where presumably acquired must be reported.[20]

HIV/HBV prevention: Reporting HIV and HBV infection is covered both by the communicable disease provisions and also by specific provisions designed to "promote the health and safety of patients and regulated persons [including licensed physicians, dentists, nurses, physician assistants, and other health care providers] by reducing the risk of infection in the provision of health care."[21] Minnesota law provides for four types of reporting: voluntary, mandatory, self, and infection-control reporting. Individuals and institutions required to make reports concerning HIV and HBV infection under the communicable disease provisions, discussed above, are also required to notify the commissioner of health if they are aware that the "reported person" is also a regulated person.

Possible exposure of EMS personnel to infectious disease: Hospitals and freestanding emergency

‡Note that Minnesota Rule 7200.4700, subpart 2 (1993) indicates that a psychologist may only release confidential patient information to warn a potential victim if the release is necessary to "protect against a clear and substantial risk of imminent serious harm."

medical care facilities that receive patients cared for by emergency medical services (EMS) personnel[§] must adopt a post-exposure notification protocol for EMS personnel who experience a significant exposure to a patient's blood or bodily fluids. This protocol must include, among other things, a method for EMS personnel to notify the facility of the possible exposure, a process to investigate significant exposures reported by EMS personnel, and a process to determine whether the transported patient in question is infected with the viruses causing hepatitis B or AIDS.[22]

Once a facility has been notified of a significant exposure, it must ask the patient to consent to blood testing to determine whether he or she has been exposed to the AIDS or hepatitis B virus. The patient must be told that the test results, without personally identifying information, will be reported to the EMS worker. Unless the patient is a prisoner who is in the custody or under the jurisdiction of correctional authorities as a result of a criminal conviction, the patient must also be informed that he or she has the right to refuse to be tested. If the patient dies before having the opportunity to consent to testing, the facility must conduct HIV and hepatitis B testing, and the consent of the decedent's representative is not necessary. If the test is conducted, the facility must report the results, without personally identifying information, to the exposed worker and to a designated agent of the EMS agency that employs or utilizes the services of that worker. The patient, or a representative of a deceased patient, must also be informed of the test results. A facility must not disclose personally identifying information about a patient without a written release signed by the patient or, if the patient is deceased, by the patient's personal representative.

§The term EMS personnel is defined broadly under Minnesota law, including, for example, individuals who render emergency care at the scene of an accident and who would qualify for immunity from liability under the good samaritan law. Minn. Stat. § 144.761 (1994).

Sexually transmitted diseases: Physicians are required to make reports designed to control the incidence and spread of sexually transmitted diseases. The reporting provisions relating to communicable diseases, discussed above, apply to sexually transmitted diseases. If, however, a person has a certain type of sexually transmitted disease, physicians must also file a "special report."[23] Physicians must immediately report to the commissioner of health the name, address, and other relevant information regarding anyone known or suspected of being infected with syphilis, gonorrhea, or chancroid who refuses examination or treatment. Physicians who have reason to believe that an individual with any of these diseases has not completed therapy must also notify the commissioner immediately. Finally, physicians who treat individuals with any of these diseases must notify the commissioner of the names and addresses of sexual contacts who may be infected.

Cancer surveillance: The commissioner of health has established a statewide cancer surveillance system. Health care providers, including, but not limited to, physicians, hospitals, clinics, and medical laboratories, are required to prepare a detailed record of each case of cancer treated or seen by the provider.[24] These case reports must be forwarded to the commissioner of health and must include the identity of the patient and provider, along with certain cancer diagnostic information. Upon request of the commissioner, providers shall also report information regarding race, ethnicity, and occupational history of individuals with cancer. To assure quality and completeness of case reports, each reporter must allow the commissioner to inspect the demographic portions of a patient's medical record or medical records related to the cancer diagnosis.[25]

Traumatic brain and spinal cord injuries: A hospital treating an individual with a traumatic brain or spinal cord injury is required to report certain information about the patient and the injury to the commissioner of health.[26,27] The terms "traumatic brain injury" and "spinal cord injury" are defined by both statute and rule and include injuries leading to certain temporary and permanent disabilities and death. The report must include data regarding the patient, injury circumstances, nature of the injury, and the reporting source. The report must be submitted to the commissioner of health on forms provided by the commissioner or by some other means approved by the commissioner and must be submitted within 60 days of the patient's death, discharge, or transfer from an acute-care setting. Hospitals must also cooperate with the commissioner in the conduct of "registry information validation studies" by providing access to patient medical records.[27]

Suspicious wounds and burns: A number of health care professionals, including physicians, nurses, and pharmacists, are required to report injuries caused by the discharge of a firearm and any wounds that the reporter has reasonable cause to believe have been inflicted on a perpetrator of a crime by a dangerous weapon other than a firearm. Among the dangerous weapons included are certain combustible or flammable liquids, devices designed as weapons and capable of causing death or great bodily harm, and any fire that is used to kill or inflict great bodily harm.[28] The report must be made to the police department or county sheriff immediately by telephone or in person and supplemented later with a letter. Health professionals must also file a written report with the state fire marshal after being asked to treat certain burn wounds.[29]

Reports to mental health ombudsman: The ombudsman for mental health and mental retardation acts as an advocate for persons receiving services or treatment from certain agencies, facilities, or programs for mental illness, mental retardation or related conditions, chemical dependency, or emotional disturbance. If a person protected by the ombudsman dies or suffers serious injuries, the facility or program serving the person must notify the ombudsman within 24 hours of the injury or death.[30] The ombudsman also may examine records of an agency, facility, or program under certain circumstances.

Requests from the coroner: Attending physicians or others with knowledge of a violent, unusual, or mysterious death must report it to the coroner.[31] If the coroner requests health-related records or data regarding such a death, the records and data must be promptly made available. Certain data collected and/or maintained by governmental entities are not covered by this mandate.

Missing child: If a child is reported missing, a law enforcement agency may issue a written declaration stating that an active investigation is being conducted to find the child and that identifying data are necessary to further the investigation. Identifying data include dental and/or skeletal x-rays and related information created in the course of providing dental or medical care to a child before his or her disappearance. When a written declaration signed by a peace officer is presented to a health care facility, the facility must provide the law enforcement agency with access to the child's identifying data.[32]

Requests from the Board of Medical Practice: Any physician who is the subject of an investigation by or on behalf of the Board of Medical Practice must cooperate fully with that investigation. Cooperation includes providing copies of patient medical records, as reasonably requested by the board, to assist in the investigation. If the board does not have the patient's written consent for record release, the physician under investigation must delete any patient identifying data in the record before providing it to the board.[33]

Physicians' own medical records may be released to the board without their consent under certain circumstances. If the board has probable cause to believe that a physician has engaged in conduct considered grounds for disciplinary action, it may obtain medical data and health records relating to the physician, whether a licensee or an applicant, without the physician's consent. The medical data may be obtained from certain providers, insurance companies, or governmental agencies.

Court orders, search warrants, subpoenas: Court orders and search warrants are documents issued by a court or a judge. They may be used to compel the recipient to produce medical records for the court or law enforcement officers. Subpoenas may also request medical records. If a provider receives a valid court order or search warrant for medical records, the provider should generally comply with the request, even if patients have not consented to the release of the records. If, however, a provider receives a subpoena, the provider may need to obtain patient consent before releasing any medical records or ask the court how to proceed. Complicated issues may arise when health care providers are faced with subpoenas, court orders, and/or search warrants asking for patient medical records. A thorough discussion of these issues is beyond the scope of this article, and providers should consult with legal counsel if they receive any of these documents.

Conclusion

The new notice law is intended to inform patients about their right to obtain access to their own health records and the right of third parties to gain access to health records without patient consent. In almost all instances, patients have a right to gain access to their own health records and to obtain copies of information in their health records. Although patient consent is generally required before health records may be released to third parties, there are numerous exceptions to this general rule. The new notice law is likely to generate patient questions and heighten awareness about the legality of health record releases, so it is important for providers to become familiar with the key laws related to health records. MM

Michelle Boynton and Jean Paltzer-Fleming are attorneys with the law firm of Fredrikson & Byron, P.A., in Minneapolis.

For a copy of this article with full citations, contact the authors at 612/347-7000.

For more information about the patient record notice, contact Mary Sarazin-Timmons at the Department of Health, 612/282-5648.

REFERENCES

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2. Minn. Stat. § 144.335, subd. 2 (1994).
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4. Minn. Stat. § 144.4175, subd. 1 (1994).
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28. Minn. Stat. § 609.02 (1994).
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31. Minn. Stat. § 390.11 (1994).
32. Minn. Stat. § 299C.56 (1994).
33. Minn. Stat. § 147.131 (1994).

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ACCESS TO HEALTH RECORDS PRACTICES AND RIGHTS

DRAFT

RELEASE OF HEALTH RECORDS AND CONFIDENTIALITY

Certain federal and state laws protect patients' rights to confidentiality of their health records. A health care provider or a person who gets health records from a provider, may not release a patient's health records without a signed and dated consent from that patient. Sometimes the law makes exceptions.

Under Minnesota law, a patient may review any information in his or her health records, regarding any diagnosis, treatment and prognosis. If a patient asks in writing, a provider must give the patient copies of either the records or copies of a summary of the information in the records unless the provider determines that the information is detrimental to the physical or mental health of the patient, or is likely to cause the patient to inflict self harm, or to harm another. Minnesota statute sets a maximum fee charged for finding and copying records. If the copy requested is for current care, there is no charge.

RELEASE OF HEALTH RECORDS WITHOUT PATIENT CONSENT

Sometimes health record information may or must be released without the patient's consent. The following are some, but possibly not all, examples:

- In a medical emergency
- When a federal law requires it
- When someone receives a court order or a federal grand jury subpoena requiring release of health information
- Under Minnesota law to the following persons or organizations for specific purposes:
  - Department of Health
  - Department of Human Services
  - Department of Public Safety
  - Department of Commerce
  - Department of Employee Relations
  - Department of Labor and Industry, insurers and employers in worker's compensation cases
  - Office of Mental Health Practices
  - Ombudsman for Mental Health and Mental Retardation
  - State Fire Marshal
  - Health Boards
  - Community Action Agencies
  - Health professional licensing boards or agencies
  - Schools and childcare facilities may transfer immunization records without consent
  - Law enforcement agencies
  - Public or private post-secondary education institutions
  - Local welfare agencies
  - Medical examiners or coroners
  - Medical or scientific researcher
  - Minnesota Health Data Institute
  - Potential victims of serious threats of physical violence
  - Guardians or conservators of incompetent persons
  - Parents/ legal guardians of a minor who is being treated where failure to inform could create serious health problems
  - Insurance companies paying for independent medical examinations

People and Places Making Medical News

People

'U' Interim Head of Surgery

The University of Minnesota Medical School named surgery professor **Frank Cerra, M.D.**, to a one-year term as interim head of the Surgery Department. Cerra, a specialist in intensive care, will replace Edward Humphrey, M.D., who is retiring from academic medicine. Humphrey became acting head of the department in February 1993 following the resignation of John Najarian, M.D. A search committee for a permanent department head will be formed when a permanent medical school dean is appointed.

Blues Senior Vice President

Blue Cross and Blue Shield of Minnesota has named **William Riley, Ph.D.**, senior vice president. Riley, who will continue his role as chief executive officer of Aspen Medical Group, is also the president and chief executive officer of the BCBSM/Aspen joint venture, which the groups formed in October 1993.

MHA Board Members

The Minnesota Hospital Association has announced that **Tim Hanson**, president of HealthEast, will be its 1995 board chair, and **Dale Rings**, director of state government relations for the Mayo Foundation, chair-elect. The MHA elected the following trustees-at-large: **Raymond Christensen, M.D.**, medical director and chief of staff at Mercy Hospital and Health Care Center in Moose Lake; **Roger Metz**, CEO of Winona Community Memorial Hospital; and **Richard Norling**, president and CEO of Fairview Health System. Trustee delegates to the AHA are: **Michael Fay**, independent insurance agent in Hibbing and member of the University of Minnesota Health System Board of Directors, and **James Rundquist**, veterinarian and chair of the Waseca Area Memorial Hospital Board. It also named **John Frobenius**, president of St. Cloud Hospital, as an AHA delegate and **Scott Wordelman**, president and CEO of Chisago Health Services, as an alternate delegate to the AHA.

Places

UMHC and FRMC Open 'The Birthplace'

The University of Minnesota Hospital and Clinic (UMHC) and Fairview Riverside Medical Center (FRMC) have developed "The Birthplace," a new obstetrical and infant services program for normal pregnancies and high-risk complication births. The collaboration is intended to address declining births at UMHC and FRMC's lack of a neonatal intensive care unit (NICU). The program, the first of its kind in Minnesota and one of only a few in the nation, combines community-based care and expertise with an academic medical focus, according to a news release issued in October. The university's obstetrics/gynecology and pediatrics residents will receive part of their training at The Birthplace, joining university family practice residents.

The Birthplace is located at FRMC's Riverside East building in Minneapolis. FRMC owns and operates the obstetrical unit and the Perinatal Diagnostic and Testing Center, and UMHC owns and operates the new NICU located near The Birthplace in a new fourth-floor addition to the Riverside East Building. UMHC's obstetrics patient care unit has closed, as has one FRMC nursery.

Park Nicollet to Open Breast Diagnostic and Research Center

Park Nicollet Medical Center has announced plans to open the Jane Brattain Breast Diagnostic and Research Center as part of an $18 million, 105,000-square-foot expansion of its St. Louis Park campus. The center, expected to open in February, will offer mammograms, diagnostic work-ups, biopsies, and surgical consultation. Radiologists, technologists, nurses, and support staff from Park Nicollet will operate the center.

The center was named for Park Nicollet benefactor Jane Brattain, who donated most of the money necessary to purchase the equipment at the center.

WestHealth Medical Complex

A new medical complex called WestHealth opened in September in Plymouth. It is the result of a 1992 agreement between Abbott Northwestern and North Memorial hospitals to collaborate rather than compete for patients in the northwestern part of the Twin Cities. The $30 million, six-story outpatient facility includes surgery suites, CT scans, MRI, ultrasound, and doctors' offices. The facility is completely leased by about 20 practice groups. WestHealth, which is a nonprofit corporation separate from its individual hospital owners, hopes to break ground on a fitness center—the second building of its proposed eight-building campus—by spring of 1995. It also plans to open a birthing center, senior citizen center, and child care center in the future.

HealthEast Medical Campus

HealthEast has announced plans to build a 60-acre medical campus in Inver Grove Heights near the Lafayette Freeway that will be a combination of outpatient, short-stay, and community-based health care services.

The seven-building facility will

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serve Inver Grove Heights, West and South St. Paul, Mendota Heights, Eagan, Cottage Grove, Newport, St. Paul Park, and Woodbury. Construction is anticipated to begin within six months to a year and should last several years.

Children's Introduces Pediatric Residency

Children's Health Care–Minneapolis is offering a new postgraduate pediatric residency for physicians interested in learning more about one of 17 pediatric subspecialties. The "mini-residency" is an alternative to traditional continuing medical education options and offers hands-on training for primary care physicians. Participants choose one-, two-, or three-day rotations at Children's–Minneapolis, spending time with physicians in their chosen specialty of interest.

'U' Children's Hospital Gets New Name

The University of Minnesota Variety Club Children's Hospital has changed its name to University-Variety Hospital for Children, shortened to "U Kids." The change reflects the University of Minnesota Health System's efforts to be more approachable and will help distinguish the children's medical center from the University of Minnesota Hospital and Clinic, which shares the same space as U Kids, said Greg Hart, president of the University of Minnesota Health System.

Socioeconomics

Hibbing Groups Affiliating With U of M Health System

The University of Minnesota Health System has reached preliminary agreements to form affiliations with Hibbing's Mesaba Clinic and Mesabi Regional Medical Center. UMHS president Greg Hart said that UMHS looks forward to solidifying the relationships it already has with the two organizations through affiliations. Discussions with both the clinic and medical center are expected to take three to four months to reach closure, and the agreements are subject to the approval of the involved governing boards.

Mayo Offers New Plan for IBM

Mayo Clinic has announced a new health plan designed to offer local managed health care to IBM Rochester employees. Mayo Choice—A Health Plan For IBM is a managed care program option offering primary care at the following locations: the Mayo Clinic in Rochester, Kasson, and Kenyon; Community Clinics—A Mayo Regional Practice in Plainview and Wabasha; and Olmsted Medical Group locations in Rochester, Byron, Chatfield, Elgin, Hayfield, Pine Island, St. Charles, Spring Valley, and Stewartville, Minnesota. When specialists are needed, a comprehensive range of physicians is available by referral. Traditional IBM medical plans will still be offered.

HealthEast Puts Bethesda on Market

HealthEast has plans to sell its Bethesda Lutheran Hospital and Rehabilitation Center in a move to downsize its operations and seek a more efficient use of space. The eight-acre center, located in St. Paul near the Capitol, employs about 350 people and has buildings that total around 400,000 square feet. As *Minnesota Medicine* goes to press, the state of Minnesota is considering purchasing the hospital and center. If the facility is sold, successful campus programs will be relocated, said Scott Batulis, vice president of administration for Bethesda, in a September 24 *St. Paul Pioneer Press* article.

Growth in State Health Care Costs Slows

Minnesota HMOs experienced a decline in premium revenue growth for 1993, according to Allan Baumgarten, a Minneapolis-based researcher on health care policy and finance. Key findings presented in Baumgarten's *Minnesota Managed Care Review 1994* show the following trends: The average increase for commercial HMO plans was 5.8 percent in 1993, compared with 16.9 percent in 1990. The annual surpluses increased from $66.2 million in 1992 to $73.8 million in 1993, with half of the HMOs' surpluses coming from investment earnings on their reserves. As a result of recent health plan mergers, by the end of 1993, three companies commanded nearly 80 percent of the 3.2 million Minnesota residents in managed care plans. Baumgarten identified two growth areas for managed care companies: Medicaid and administration of self-funded benefits plans (enrollment in self-funded plans jumped from about 890,000 at the end of 1992 to about 1,250,000 in 1993). Enrollment in the Minnesota Comprehensive Health Association has begun to decline slowly, and

use of inpatient hospital days by commercial HMO enrollees has decreased.

Minnesota Law Firms Sue Norplant Maker

Two Twin Cities law firms, Miles Lord & Associates and Brosnahan Joseph Lockhart & Suggs, have filed a suit against Philadelphia-based Wyeth-Ayerst Laboratories, manufacturer of the implanted contraceptive device Norplant. The current lawsuit, alleging the device has caused severe health problems for women, represents one woman's claim, but the law firms are collaborating with firms across the nation to ask that the cases be declared a class action suit on behalf of thousands of women nationwide. Both Minnesota firms were bombarded with responses from more than 800 women having difficulty with the implant. Reported side effects from the hormone-releasing capsules inserted in the upper arm include excessive weight gain, excessive menstrual bleeding, severe headaches, dramatic mood swings, hair loss, and suicidal tendencies.

According to Wyeth-Ayerst, quoted in the September 16 Minneapolis-based *Star Tribune*, "The Norplant system is one of the most extensively studied contraceptive methods. It has been tested for over 20 years."

Rates, Trends, Data

Twin Cities Health Care Gets Top Ranking

The Twin Cities area and Seattle ranked highest in a health care study of selected metropolitan areas in the United States. The study, commissioned by Northwestern National Life Insurance Company of Minneapolis and conducted by T.E. Eckstein & Associates, Inc., looked at 16 cities in terms of 17 measurements of health care access, quality, and cost. The Minneapolis/St. Paul area was in the top one-third of all cities in 16 of the 17 categories. The only category in which it ranked below the top third was in the percentage of mothers receiving adequate prenatal care.

Of the 16 cities, the Twin Cities had the lowest proportion of families at poverty level; the lowest percentage of births to mothers 17 or younger; the lowest percentage of population reporting fair or poor health; the lowest number of specialists per family doctor, and the highest number of large businesses per 100,000 people. MM

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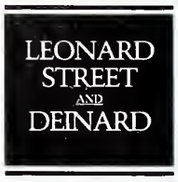

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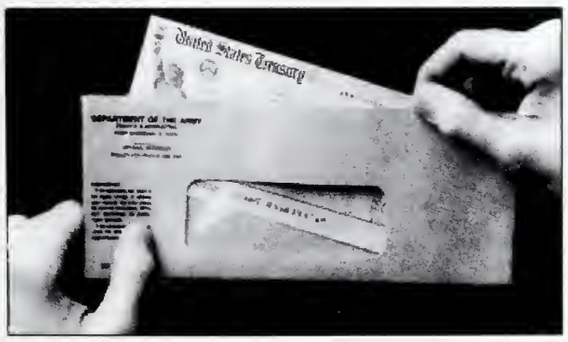

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A Calendar of Continuing Medical Education Courses

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NOVEMBER 1994

Nov. 6 **Audiology Videoconference** Mayo Foundation and Sheldon Reese Foundation; Mayo Medical Center, Rochester, MN. CONTACT: Mayo Foundation, Postgraduate Courses, Section of CME, 200 First Street SW, Rochester, MN 55905; 507/284-2509 or 800/323-2688.

Nov. 10-12 **Strategies in Primary Care Medicine** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Nov. 11-13 **Clinical Mycology** Mayo Medical Laboratories; Mission Inn, Howey-In-the-Hills, FL. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Nov. 12 **Excimer Laser Course** Allina; Phillips Eye Institute, Minneapolis, MN. CONTACT: Allina Office of Medical Education and Research, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

Nov. 12-13 **Monitoring Neural Function During Surgery** Mayo Foundation; Mayo Foundation, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Nov. 13 **Exercise Gas Exchange in Heart Disease** University of Minnesota; Dallas, TX. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Nov. 13-14 **Building Families: Ethical and Policy Issues in Adoption** University of Minnesota; Hotel Sofitel, Bloomington, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Nov. 17-18 **Breaking the Cycle of Violence** St. Paul-Ramsey Medical Center; Holiday Inn International Airport, Bloomington, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Nov. 17-18 **Pediatric Advanced Life Support** Children's–Minneapolis; Children's–Minneapolis, MN. CONTACT: Betsy Julius, Children's–Minneapolis, 2525 Chicago Avenue South, Minneapolis, MN 55404; 612/863-6206.

Nov. 18-19 **Point-of-Care Testing/Phlebotomy** Mayo Medical Laboratories; Stouffer Madison, Seattle, WA. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Nov. 18-19 **Current Approaches to the Management of Eating Disorders** University of Minnesota; Holiday Inn Metrodome, Minneapolis, MN. CONTACT: Rebecca Noren, Registrar, Office of CME, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

DECEMBER 1994

Dec. 1-3 **Annual Cardiopulmonary Medicine Update** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Dec. 2 **Infectious Diseases and International Health** Hennepin County Medical Center, Hennepin Faculty Associates-Office of Academic Affairs, and the University of Minnesota; Marquette Hotel, Minneapolis, MN. CONTACT: Ann Samways, CME Coordinator, 612/347-2078; or Robin Hoppenrath, Manager, Office of Academic Affairs, 612/337-7128.

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- ***Management of Diabetes in Pregnancy***...Dr. Oded Langer, University of Texas
- ***New Mammography Guidelines***...Dr. Devra Davis, Assistant to the Secretary of Health, Washington, DC

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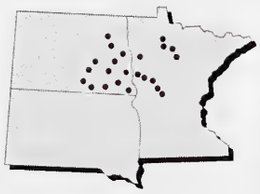

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Mankato Clinic, Ltd. is seeking additional BC/BE physicians in the following specialties: orthopedics, radiology, invasive cardiology, oncology/hematology, family practice, and general internal medicine. The Mankato Clinic is a 59-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. M. P. Wheeler, President, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (10/93-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

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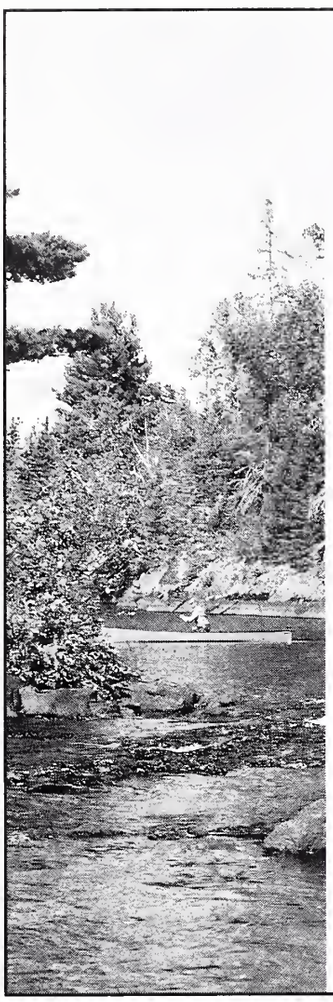

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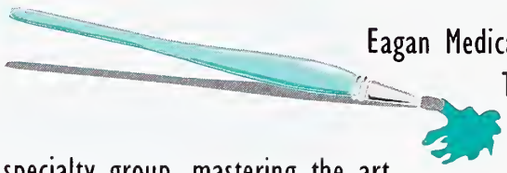

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Marriages of Convenience

Charles R. Meyer, M.D.

We sing a song of '94
Which shall rest in health care lore
As dalliance, dates, and deals
With none who really know the score.

We thought we knew who liked whom
But no longer mates can we assume.
Medica likes 'Span, MedCenters likes the 'Health
At least for now, but not 'til doom.

And yet when all is said and done,
Will we know who has lost and won?
Could HMO=PPO=ISN?
How large a circle we have run.

"The Twin Cities health care scene is like an organizational Peyton Place."

Life doesn't get any simpler. The last year brought increased consolidation and vertical integration to Minnesota medicine. Unfortunately, all the matchmaking didn't simplify our health care family tree. The Twin Cities health care scene is like an organizational Peyton Place—it's hard to know who's sleeping with whom.

This month's end-of-the-year cover story summarizes these puzzling relationships. We also profile Steve Wetzell, whose Business Health Care Action Group (BHCAG) flexed business' muscle two years ago and sent everybody scrambling.

In preparation for this column, I've been watching a lot of soap operas, so I'll try to make sense of the social scene. Here's my story guide to the Minnesota health soaps:

• Buyer power emerges—Like an overbearing date, BHCAG businesses loudly announced that since they pay the bill, they want to dictate the product.

• Providers get tighter—Doctors have snuggled together in PHOs, MD-only organizations like Minnesota Specialty Physicians, Criterion HealthCare Network, Fairview Physician Associates, and Physicians Service Network. Meanwhile, a number of hospitals continue to search for new mates.

• Insurers and providers get cozier—The previous "handshake" relationship between insurers and providers got friendlier with vertical integration alliances like Criterion-NWNL, Medica-HealthSpan, Group Health-MedCenters-Ramsey, Blue Cross-Aspen-Fairview-University of Minnesota.

• Far from monogamous, the relationships cross system lines—For example, Comprehensive Medical Care (Allina-owned) deals with HealthPartners; MeritCare deals with Allina and HealthPartners. Everybody is talking to, if not smooching with, everybody.

• The fallout from hospital downsizing and mega-plans continues—The Eveleth Hospital and Divine Redeemer found no friends and closed. Like a jilted, quiet lover amidst bigger, louder rivals, Prudential announced its managed care product was leaving town.

• Mayo gets friendly—Previously aloof from the managed care matchmaking and likely responding to its $6.3 million loss in 1993, Mayo has come out of its shell, forming an alliance with HealthPartners; signing a coverage agreement with PreferredOne; developing family practice residency programs with hospitals in St. Cloud, Minnesota, and Des Moines, Iowa; and purchasing or affiliating with smaller clinics in its referral area.

• Everyone wants to link up electronically—Like a teen who has discovered the phone, all players are vying to connect with information links and computerized medical records. Relationships go nowhere without communication.

• The Twin Cities becomes the Las Vegas marriage mill of health care—A 25-doctor network in Florida was recently formed to negotiate with managed care. Remarkably, 80 percent of the physicians currently have no managed care contracts. Minnesota is "socially progressive," a veteran of more marriages, failed and successful, than Liz Taylor.

As with all soap operas, the real question here is, will everyone live happily ever after? Or will the future for Minnesota health care hold an endless series of new and possibly dysfunctional relationships?

And are these relationships really new? I recently reviewed some editorials written from 1975 to 1980 by longtime *Minnesota Medicine* editor Dick Reece. Though the acronyms and labels were different, the themes were disturbingly familiar. So, is an ISN or isn't it? Stay tuned. MM

Applying Market Power– The BHCAG Is Flexing Its Muscle

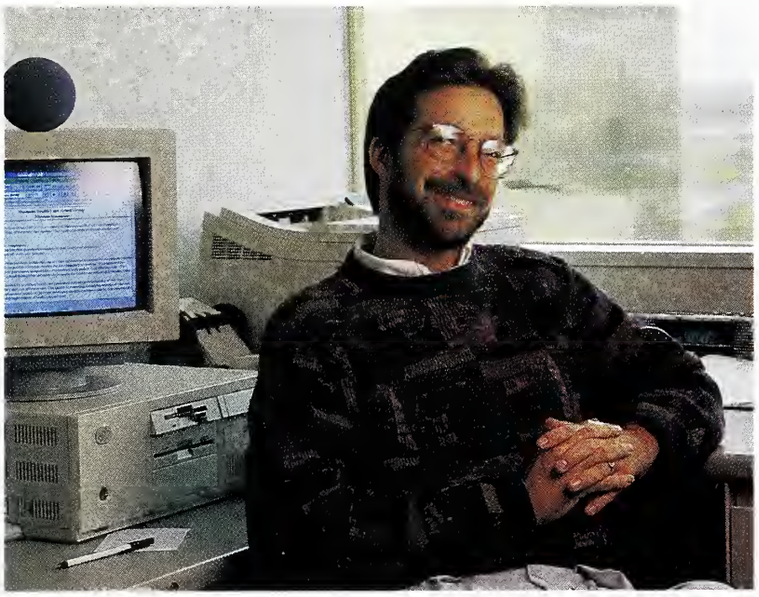
Business Health Care Action Group Executive Director Steve Wetzell is leading an effort to create incentives for providers to deliver quality care more efficiently.

By Thomas Allen

A powerful tug-of-war is going on, and Steve Wetzell is in there pulling. The battle is between those favoring a government-based approach to health system reform and those advocating market-based reform. Wetzell, executive director of the Business Health Care Action Group and a member of the Minnesota Health Care Commission, is dug in on the market side. "We want to demonstrate that we can create incentives that will enable the private sector to solve this problem without a lot of regulation," he says.

Wetzell, 38, was born in Iowa, but raised in the Twin Cities. His wife, Nancy, is a political appointee in the Clinton administration. "Not in health care," he says and laughs. She's with the Department of Energy and commutes home on the weekends.

Wetzell earned his undergraduate degree in business administration from the University of Minnesota in 1978 and then a graduate degree in human resources management in 1980. He spent the '80s with Northern States Power, working in labor relations, compensation, and benefits management.



As NSP's benefits manager, Wetzell became familiar with managed care in the latter half of the decade. In 1990, he headed a project at NSP to introduce managed care to more than 7,000 union and nonunion employees. He joined First Bank System in 1991 and implemented a national managed care plan for 8,500 employees in eight states in January 1992. "Managed care was a common strategy that I tried to use to get a handle on cost and quality," he says.

While he saw the value of managed care, he also realized its shortcomings. "The biggest realization I had was that there wasn't a product on the market that had sufficient provider ownership," Wetzell says. "I don't mean ownership in literal terms, but ownership in which the providers had really bought into the product the health plan was trying to sell. Instead, we were buying people to inspect the providers in order to control utilization—there was still an adversarial relationship between the health plan and the providers."

In 1992, 14 of Minnesota's largest employers formed the Business Health Care Action Group (BHCAG) to address the rising costs of

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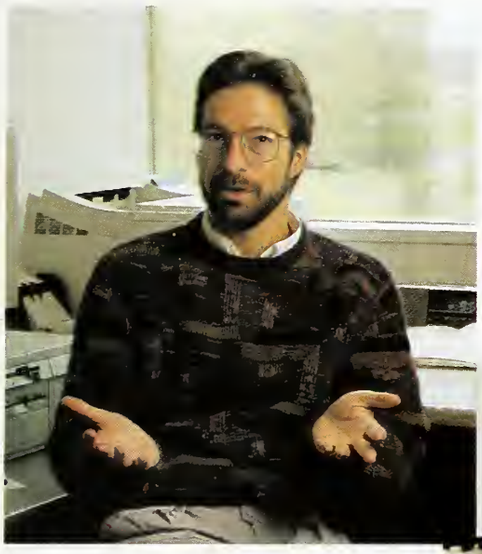


"We're trying to restore the proper balance of power between care systems, health plans, purchasers, and consumers so that the health plans don't play the dominant role in the market."

–*Steve Wetzell*

health care. As a representative of First Bank System on the action group's board of directors, Wetzell was impressed by BHCAG's "more enlightened philosophy," which, he says, centered on working with providers to develop incentives to maximize quality at the lowest possible cost.

"The thing that was so appealing to me was that the action group realized it was their money being spent, and it wasn't being spent in a way that created the right incentives to align all the stakeholders toward a shared goal," Wetzell says. "And that's what they're trying to achieve. That represents real breakthrough thinking."

Rather than simply buying an "off-the-shelf" product offered at a discounted price by a health plan anxious to serve BHCAG's members, the action group issued a request for proposals, demanding an integrated systems approach to delivering health care. Essentially, the action group was beginning to address the shortcomings that Wetzell had seen in managed care.

In mid-1992, the action group chose the GroupCare Consortium—Group Health and MedCenters Health Plan (forerunners to HealthPartners), the Mayo Clinic, and Park Nicollet Medical Center—as its health plan and hired Wetzell as executive director.

"I was just in the right place at the right time and believed in what they were doing," Wetzell says.

Choice Plus hit the market on January 1, 1993. Nine BHCAG members offered the plan, and about 45,000 employees, retirees, and dependents enrolled. Wetzell says data indicate that in 1993 Choice Plus costs were 11 percent below expected costs of comparable HMOs in the Twin Cities.

The success of that first year was evident in January 1994, when 20 of BHCAG's 21 members offered Choice Plus and enrollment surged to nearly 90,000 (it's now closer to 100,000).

Not Just Cost Shifting: A Solution

Wetzell briskly defends BHCAG against accusations that the action group is simply using its muscle to cut the best deal for itself and shift its costs to smaller groups and individuals. "If we were strictly negotiating discounts on a fee-for-service basis, that would be absolutely right," Wetzell says.

But the action group, according to Wetzell, is trying to use its clout to create a structural change in how health care is delivered. "We're trying to create incentives for providers to look at the way they can more efficiently deliver care to their entire population."

To put its money where its 100,000 mouths are, BHCAG is working with the Employers Association and the Minnesota Chamber of Commerce to develop a similar purchasing coalition for small business. "All buyers should start sharing [the goal of high-quality care at the lowest possible cost] as an incentive to give

WETZELL continued on page 52

Blueberry Muffins & Mystery Novels

Small gestures of kindness remind this physician that medicine is all about people taking care of people.

By Mark Linzer, M.D.

"What's that?" I asked my medical resident just before morning rounds began.

"It's a muffin," she said. "Mrs. Tyler on Farnsworth Five likes muffins, especially blueberry. This one came on her tray this morning. It's so hard, I'm afraid it might crush her jaw."

I picked it up. It did seem like a cross between a hockey puck and a golf ball. I thought little else about it and we started rounds.

A few days later we went out to breakfast to say goodbye to our medical students who were rotating off service. I still can't remember what inspired me to say, "Let's buy a blueberry muffin for Mrs. Tyler. We can drop it off on the way back to the conference room."

We bought the muffin and stopped by her room to give it to her. Mrs. Tyler was 83 years old, paraplegic from spinal stenosis, bed-bound, and suffering from a deep decubitus ulcer. Her oral intake was lousy, and we were considering a feeding tube. She was a pleasant woman, alert and quite sharp mentally. However, given her condition, she usually appeared depressed. She brightened when we presented her with the muffin. I also noticed that she was reading a Dick Francis novel.

"Do you like mystery novels?" I asked.

"All of them!" she exclaimed. As we retreated to our conference room, the house staff informed me that she read a book every two days and was rapidly finishing the hospital's entire stash of mysteries.

The month of attending was brutal. Patients were admitted to my service continually. Calls from various house staff came at midnight, 2 a.m., anytime. We ran 20 to 30 patients on service all the time. Some were dying, others were acutely ill, and many simply lingered, waiting for placement in a nursing home. Mrs. Tyler was in the last category.

Something provoked me to think of Mrs. Tyler again. I began to scan the bookshelves at home for mystery novels. My wife, an avid mystery reader, assisted. We found more than a dozen. I brought several to Mrs. Tyler the next day. She was delighted! "Thank you so much," she said. "I'll give them back when I'm finished."

The next few weeks were demanding, exhilarating, exhausting, challenging, and fun. But the days in the trenches were punctuated by periodic deliveries of blueberry muffins and mystery novels to Mrs. Tyler. I remember wondering why I was doing this. Regardless, it seemed to be making both of us happy. Mrs. Tyler loved the novels and muffins (muffins were all she would eat on a regular basis). I treasured the human contact, this connection with a delightful human being. Maybe I felt as though interrupting her depression with gifts of muffins and books might give her the strength to carry on.

AT THE END OF THE THIRD WEEK on service, the "Do-Not-Resuscitate" issue surfaced. Patient by patient, we discussed this decision with families and nurses, and, when dementia was not a factor, with the patients themselves.

In the conference room that day my resident startled me with, "I think Mrs. Tyler should probably be a DNR. What do you think?"

I was stopped in my tracks. First I nodded yes. Then I said, "Wait a minute." Tears welled up in my eyes. My voice caught. I tried to speak.

"I need to sort this out. I can't figure out what I'm feeling. Maybe we should talk to her."

The next day I began rounds by discussing my feelings about Mrs. Tyler and the business of DNR. I told the residents my first impulse was that I didn't want her to die. And my second: I didn't want us to "do nothing" for her. Sure, she was 83 years old and hopelessly confined to her bed. What sort of quality of life was that? But she could read, couldn't she? And communicate and feel, and wasn't that enough? I had a relationship with her. Muffins and books. How could I let her go?

ILLUSTRATION BY MARY QUINLIVAN

I HAD CROSSED THE LINE. My residents knew. I related to her in a more personal manner, without the detached concern that is supposed to define our relationships with patients. My relationship with Mrs. Tyler lacked the content of a traditional friendship: I knew little about her family, her friends, or her beliefs. But we had connected and that meant empathy, sharing, warmth, zest, and lightness. It was as if everything else was in black and white and my relationship with Mrs. Tyler was in vivid color.

The house staff and students fired off questions and told their own stories. Was it all right to attend your patients' funerals? Do these relationships compromise your objectivity? What are acceptable ways to get close to patients? I told them I thought my relationship with Mrs. Tyler was appropriate, but that if objectivity were compromised you should ask for advice from a colleague. But I really wasn't sure I knew the answers to their questions.

I also recognized that something else had occurred that day on rounds. By sharing my feelings with my team of students and house staff, I had begun to legitimize a feeling process. One of the students later thanked me—told me that this was one of the most powerful experiences he had had in medical school. My own battle with my feelings showed him it was all right to let down, that the attending is not divorced from his humanity, showed him that in the end, we are all simply people taking care of people.

Did I cross the line? Should we all be crossing the line more often? I still wonder. If we don't allow this part of medicine to grow and blossom, neither our patients nor we will be happy.

Mrs. Tyler soon headed for a bed in a local nursing home. "Thank you for helping me get through, she said.

"Thank you for helping *me* get through," I replied.

My month was over. It was time to wind down, sign out, complete discharge summaries, and argue with Quality Assurance about lengths of stay. The paperwork took over; I went on automatic: calling, dictating, writing, signing. But somewhere in the waning moments of intensity, bureaucracy, and chaos that we call medicine, I saw Mrs. Tyler's face. Had I just been battle weary after a grinding month on the wards? Or had I seized an opportunity to connect with a patient? Regardless, I'm going to do it more often. That's why I became a doctor. MM

Mark Linzer is from the University of Wisconsin, Madison.

Reprinted with permission from Linzer M. Blueberry Muffins and Mystery Novels. Ann Intern Med 1994;121:56-7. *© 1994 American College of Physicians.*

The Integration Sensation

Competition and consolidation are reshaping health care financing and delivery in the Twin Cities.

ILLUSTRATION BY ANDREW POWELL

The Twin Cities has been considered the Mesopotamia of managed care for years. Today, it continues to rank as one of the country's most competitive markets. An April InterStudy report ranked this urban area the third most competitive health

care market in the nation, behind San Francisco and Honolulu. In fact, the Twin Cities could have a shot at the top spot at the rate things are moving. Competition in Minnesota shifted into overdrive in the past two years. Health system reform and employer activism are propelling the Twin Cities and the state of Minnesota into the forefront of vertical integration.

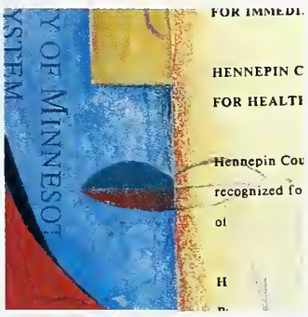
Although managed care is nothing new for the Twin Cities, local hospitals and physicians face new pressures from business and government. Undoubtedly, the experience is creating veterans of change among the physicians and health care executives who are attempting to chart a course through these turbulent waters.

Driving Market Forces

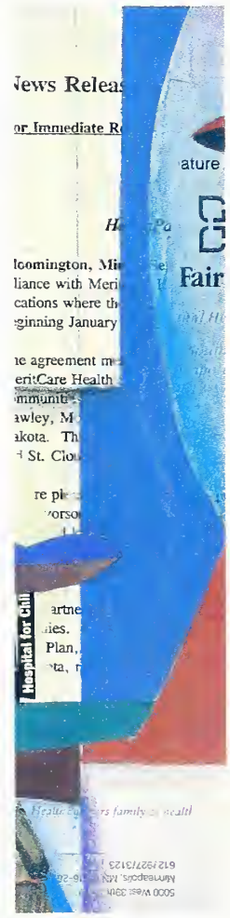
Among the forces driving competition are employer groups that are pooling their purchasing clout by forming cooperatives, such as the Business Health Care Action Group, an employer purchasing pool based in Minnetonka, Minnesota.

Health system reform legislation is another factor. The 1993 MinnesotaCare Act calls for the state's health care to be delivered using managed care and integrated service networks (ISNs)—Minnesota's own term for integrated delivery systems. The 1994 MinnesotaCare Act continues this focus. This legislation is driving payers and providers to link up in broad-based networks that agree to offer patients a full continuum of care.

The Minnesota Legislature and the Minnesota Department of Health are hammering out more details of the law and plan to phase it in over the next three years. A blueprint for legislation released in February by the Minnesota Department of Health and passed by the Legislature in May requires the networks to be nonprofit organizations that include community representatives on ISN governing boards. The ISNs are expected to use standardized benefits, utilization procedures, and measurements of quality. An information clearinghouse will be set up to disseminate network quality "report cards" to consumers. But there appears to be no requirement that ISNs operate on a capitated basis, and some are planning to continue to use fee-for-service reimbursement.



A consumer backlash developed based on fears that patients would lose access to their physicians as networks select some physicians to participate and exclude others. In response to additional concerns about over-concentration of the market in three big ISNs-to-be, the 1994 Legislature created community integrated service networks, locally controlled organizations that are limited to 50,000 members.



Both the market and these legislative initiatives have set off an unprecedented round of mergers and affiliations among health plans that have significantly altered the landscape of Minnesota's health care industry. Following is a summary and update.

HealthPartners, one of the state's largest health maintenance organizations, was formed in August 1992 with the merger of Group Health Inc. and MedCenters Health Plan. Park Nicollet Medical Center, a 375-physician medical group based in St. Louis Park, merged in the summer of 1993 with nearby Methodist Hospital, forming HealthSystem Minnesota. Last December, Ramsey HealthCare, Inc., signed an agreement to affiliate with HealthPartners. The agreement became official this summer when Ramsey HealthCare was dissolved and HealthPartners became the governing authority over the 312-bed St. Paul-Ramsey Medical Center, the 200-physician Ramsey Clinic, and the Ramsey Foundation, all in St. Paul. Medica, one of the state's largest HMOs, and HealthSpan Health Systems Corp., one of Minnesota's largest hospital systems, completed a merger August 1, 1994, and formed Allina Health System, the state's largest integrated delivery system.

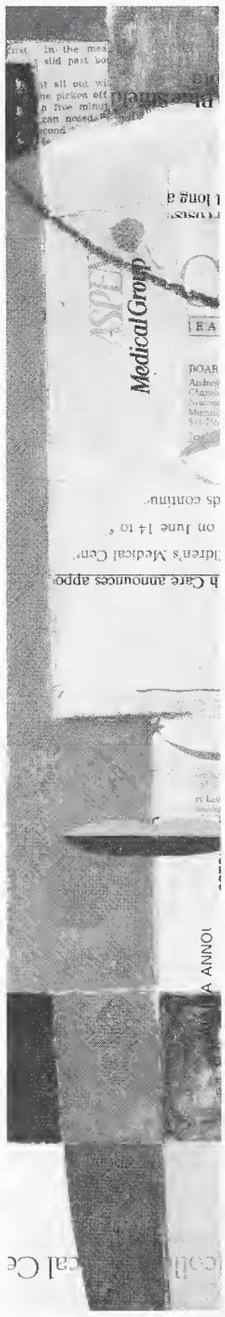
Remarkably, innovation in reshaping health care financing and delivery hasn't been the exclusive domain

of hospital systems and physicians. Blue Cross and Blue Shield of Minnesota, for example, has emerged as a new creative catalyst. Unlike the conservative, slow-moving, traditional Blues stereotype, this organization has set up strategic affiliations in recent months with provider groups throughout the state, and it is establishing an innovative, community-wide health care information highway. The largest provider partnership announced recently will link Blue Cross, the University of Minnesota Health System, Fairview Health System, Aspen Medical Group, and Fairview Physician Associates.

Insurers, hospitals, and physicians are joining forces in ways that could create cohesive templates for integrated health care delivery. But it will be interesting to watch how these new relationships are managed and how they will actually function in a competitive bidding process. The 1994 law prohibits the use of exclusive contracts, so providers are allowed to participate in multiple ISNs. While this assures them access to ISN contracts, it may be difficult for any given network to achieve competitive distinction over the long term.

Nevertheless, the rush is on to consolidate forces, and a lot more action is expected before the dust settles. HealthEast Corp., a four-hospital system in St. Paul, has been talking with several players about potential deals. Blue Cross says other organizations are interested in joining its Twin Cities alliance. With the exception of a few organizations, such as North Memorial Medical Center, Hennepin County Medical Center, and Gillette Children's Hospital, choosing partners is becoming a way of life. (For more detail on Gillette and other Twin Cities children's hospitals, see the sidebar, page 16.)

The test of any of these new alliances will be the extent to which they are truly integrated to operate more efficiently and actually provide a coordinated continuum of care. How effectively will they take responsibility for the health of their communities? What kind of job will these networks do in synchronizing hospital and specialist capacity to better fit the lower managed care demand profile? Will physicians outside of groups like Park Nicollet be able to organize themselves to participate as significant partners in the new integrated service networks? Many questions remain.



Declining Use Rates and Downsizing

"It is the obligation of all parties in health care to match the appropriate resources available to us—in terms of hospital beds, professional staff, and equipment—to the needs of our community," says Richard Migliori, M.D., senior vice president and chief operating officer of Park Nicollet. "Responsible organizations are obliged to 'rightsize' their operations so that high-quality care and excellent service are delivered at minimal cost."

Forecasters are predicting that health system reform will tighten down the Minnesota market to the point where only one hospital bed will be needed for every 1,000 people. The 1992 ratio was about triple that. According to the American Hospital Association, in 1992 there were 7,079 acute care beds in the greater Twin Cities area, which has a population of about 2.45 million people—a ratio of about three beds per 1,000 people. Given the plunging hospital use rates, only about 2,500 hospital beds will be needed in the not-too-distant future. That puts enormous pressure on providers to deploy creative strategies to reinvent themselves or face extinction.

Hospitals and specialists throughout the country are feeling pressures from declining use rates. But in the Twin Cities, they are especially vulnerable. According to the "Minnesota Managed Care Review" by Twin Cities health care consultant Allan Baumgarten, hospital days per 1,000 members under age 65 for the state's two largest HMOs were in the low 200s in 1993. Rates in the Twin Cities have dropped steadily in the past three years, according to Baumgarten's report, which notes that a national consulting firm has suggested a standard of 175 inpatient days per 1,000 population for a commercial HMO population.

Minnesota's HMOs have achieved shorter length of hospital stays than HMOs nationwide. Average length of stays for HMOs nationwide is about 4.5 days. Minnesota HMOs have average length of stays around 4.2 days.

Even more striking is the fact that many of Minnesota's HMOs achieved this level of utilization using discounted fee-for-service. "Contrary to what people think about the Twin Cities, capitation has not been a primary method of contracting," says Richard Norling, president and chief executive officer of Fairview Health System.

Approximately one in four of Medica's HMO members are in capitated prepaid health care, according to David Strand, group vice president of health plans at Allina and president of Medica. The rest of the members are covered using discounted fee-for-service and withholds. Still, a recent Medica report says hospital inpatient days for people with acute conditions was 223 days per 1,000 members in 1993, down from 237 days in 1992.

What we begin to see in the Twin Cities is an industry in the throes of contraction. But, where will all of this lead? What will the health care landscape look like over the next several years?

Larger Organizations ... Fewer Choices?

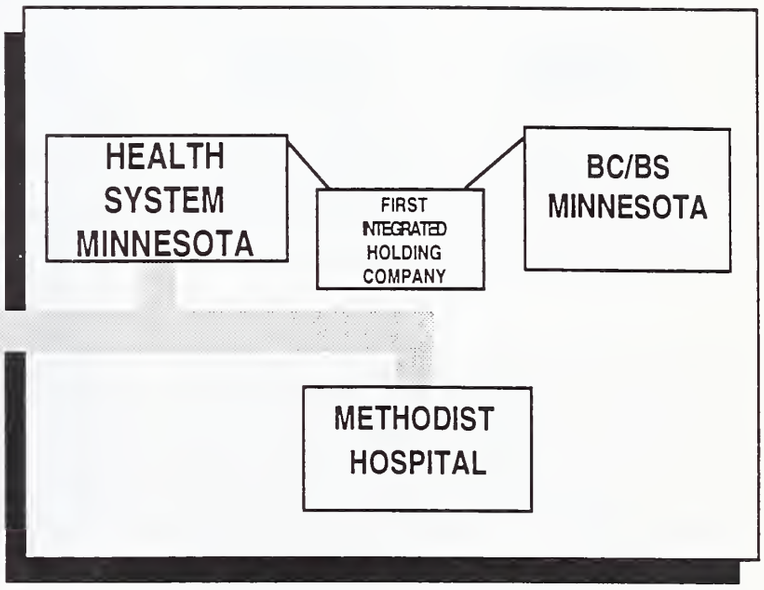
While the velocity of the movement to create integrated delivery systems may conjure visions of a market dominated by three or four organizations that proceed to swallow up all weaker players or force them to choose sides, local experts don't believe such a scenario is likely.

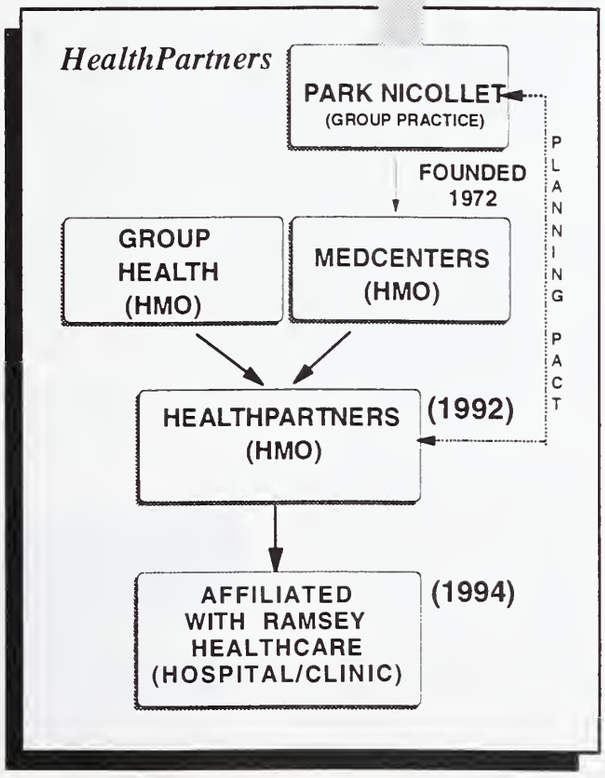
"It's going to be a long time before we see total integration or total aggregation to very few buyers or very few sellers," says Tom McCormick of The Chancellor Group, a Twin Cities consulting firm.

Why not? As alluded to earlier, many provider groups and health plans are forming strategic affiliations with a number of different networks in the same market, creating a jigsaw puzzle of overlapping affiliations that are not that different from the pre-reform cross-contractual relationships.

For example, while Park Nicollet and Methodist have cast their lot with the Blues, the two providers' strongest relationship is still with MedCenters Health Plan, the HMO that merged with Group Health to form HealthPartners. Park Nicollet actually founded MedCenters in the early 1970s, then spun it off as a separate company in the mid-1980s. The medical group's tie to the HMO is still strong. It's the source of about 60 percent of Park Nicollet's patients.

This doesn't mean that the more recent network initiatives won't evolve into more exclusive arrangements. For example, HealthPartners severed its year-old





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"MinnesotaCare is driving payers and providers to link up in broad-based networks that agree to offer patients a full continuum of care."

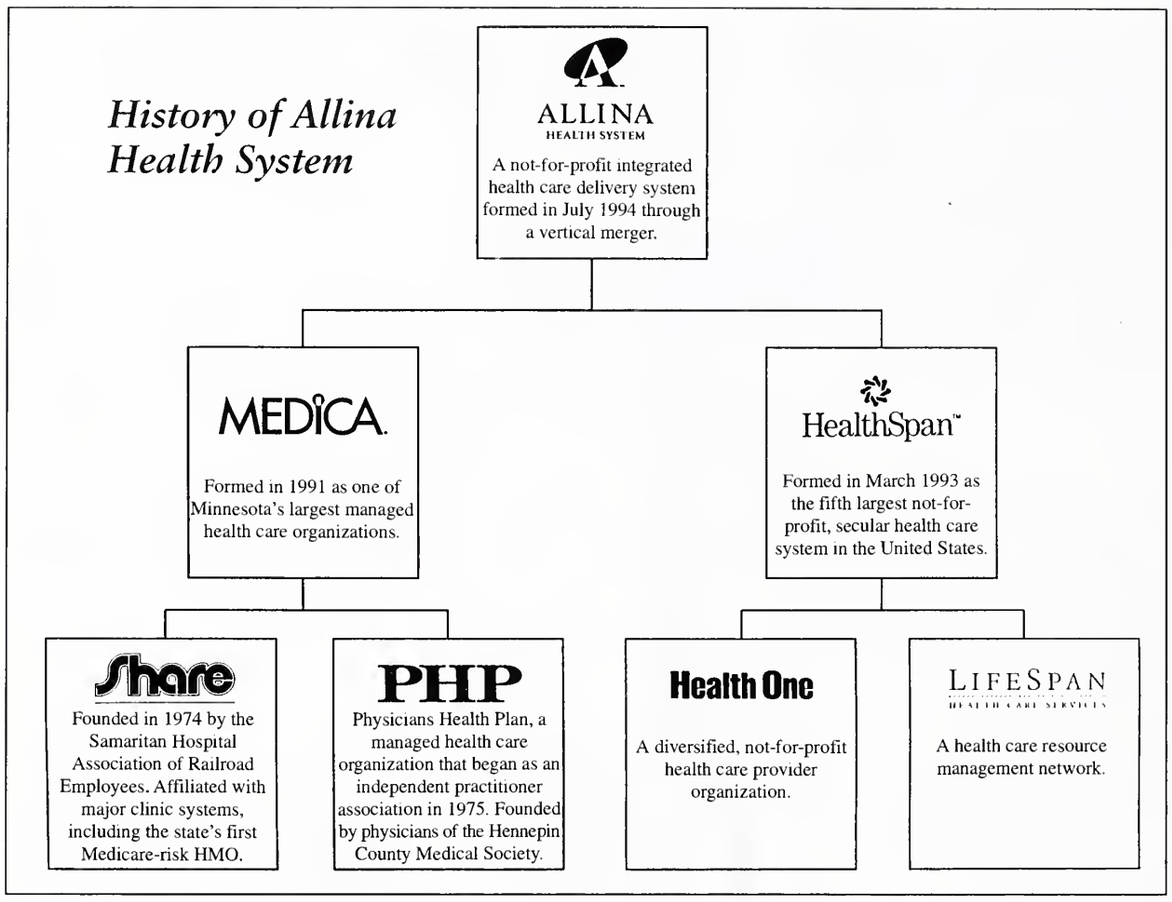


CHART COURTESY OF ALLINA HEALTH SYSTEM

affiliation with Aspen Medical Group effective May 1, 1995, following the group's alignment in a partnership with Blue Cross and Blue Shield. A HealthPartners spokeswoman said the affiliation no longer made sense once it became clear that Aspen's primary allegiance was now to Blue Cross. The 4,000 HealthPartners members assigned to Aspen clinics must choose new physicians, or change health plans, during open enrollment.

CISNs, Co-ops, and Other Reform Options

A number of factors could limit the extent of ultimate consolidation. Minnesota's specialists are making aggressive moves to survive and stay independent. Many have recently formed single- and multispecialty group practices. Specialists who can gain enough bargaining clout and demonstrate to primary care physicians an ability to hold down costs may be able to become power brokers. But it's an extremely difficult feat when there is a large surplus of specialists.

Additionally, Minnesota's 1994 health system reform law attempts to encourage integrated health plans other than ISNs. As mentioned above, it allows for the creation of locally controlled community integrated service networks. CISNs, which can begin providing coverage on January 1, 1995, can have no more than 50,000 members, and local residents must have the majority of the CISN board seats. To encourage their development, the Legislature has given CISNs more flexibility by setting lower solvency levels and by exempting them from a number of the state's current HMO requirements (see "Community Integrated Service Networks," October 1994 *Minnesota Medicine*, page 42).

As *Minnesota Medicine* goes to press, three Minnesota organizations have applied with the Minnesota Department of Health for CISN licensure: Central Minnesota Group Health Plan of St. Cloud, New Pioneer Health Plan of Willmar, and PreferredOne, a Minneapolis-based preferred provider organization. Some industry officials have said that PreferredOne, owned by Fairview Health System of Minneapolis, North Memorial Medical Center in Robbinsdale, and the 1,500-member PreferredOne Physician Associates, is not exactly what the Legislature had in mind when it created the CISN concept. If approved, the PreferredOne Community Health Plan CISN would service the same 62-county area as the PreferredOne PPO—a geographic area some have commented is larger than a typical community. Phil Griffin, vice president of public policy for PreferredOne, conceded in a recent *CityBusiness* article that the Legislature's vision may have been different, but he said PreferredOne is just trying to meet the needs of consumers. He said the CISN would look a lot like the PPO, with the major difference being that it can assume risk. PreferredOne initially con-

sidered forming an HMO, but Griffin said the CISN will allow more flexibility in terms of regulatory oversight.

If approved, PreferredOne's CISN will target small employers and will start enrolling members in the second quarter of 1995, said Griffin. Its goal is 10,000 enrollees by the end of the first year, and 50,000 by the end of the second year. "Then we'll become an ISN," he said.

Some smaller players are merging into larger systems because they lack the capital needed to form integrated systems, and it simply makes sense to join rather than compete with more dominant systems. But another provision in the new MinnesotaCare law will make it easier for the smaller players to remain independent.

In lieu of reserves, a CISN provider contract can bind providers to delivering free services if the CISN becomes insolvent. The value of those free services can be used to meet up to 30 percent of the $1.5 million net worth requirement for CISN licensure. Providers would have to be certified as "accredited capitated providers" and agree to provide services without compensation to enrollees of an insolvent CISN for up to six months after the CISN has been declared insolvent.

Any type of provider could participate in this arrangement; however, they would all have to agree to be capitated. Larger providers would have more risk under the "free-care/insolvency" provision of the law. They would also gain more control in a CISN. But the capitated risk involved with CISN contracts may deter some smaller providers from participating.

Interestingly, this creative approach to meeting CISN reserve requirements was developed by the Minnesota Hospital Association. Smaller hospital systems are apparently hoping to use it to create their own networks and avoid being subjugated to the urban priorities of larger systems. But many rural hospitals in Minnesota are already part of bigger systems such as Allina.

The new health system reform law doesn't require providers or purchasers to participate in ISNs or CISNs. Instead, it includes a provision known as the regulated all-payer option (RAPO), which will allow fee-for-service medicine to continue. Even that system hopes to reduce administrative costs by including the all-payer option in a uniform standard system of billing and utilization review.

The 1994 MinnesotaCare law also established a new concept of health care cooperatives. Based on the rural agricultural cooperative model, the law allows providers to form provider cooperatives and health plans to form network cooperatives in an innovative way to encourage further integration in the health care system (see "Minnesota Health Care Provider Cooperatives," November 1994 *Minnesota Medicine*, page 45).

While Minnesota's health care community aggressively repositions itself, the full implementation of MinnesotaCare may still be years away. But, given the dizzying array of affiliations and mergers in the last couple years, reform is clearly well underway. Regardless of the forces that might prevent full consolidation among providers and insurers, some very impressive mergers and partnerships have already been launched.

HealthPartners

The creation of HealthPartners in 1992 was precipitated, in part, by the Business Health Care Action Group, when 14 employers, now 21, joined together to pool their purchasing power (this month's Face to Face profile, page 6, features Steve Wetzell, the group's executive director). This self-insured employer group decided to contract with only one HMO, and then it went out for bids.

Group Health and MedCenters decided that a merger would create the kind of comprehensive provider network sought by the employer group. It also gave the two big companies the opportunity to collaborate on clinical systems development and medical outcomes measurement systems. The merger created an HMO with combined membership of about 580,000. Of the Business Health Care Action Group's current 250,000 employees and dependents, about 100,000 have chosen the HealthPartners health plan "Choice Plus" for their coverage.

Group Health, founded in 1957, is a network of more than 60 medical and dental centers located throughout the Twin Cities area. Its products and services are delivered through a network of 33 affiliated clinic sites. The staff model HMO employs its medical and dental staff and owns and operates its own clinics.

MedCenters Health Plan, founded in 1972 by Park Nicollet Medical Center, is a group model HMO with a network of more than 2,700 contracted physicians who serve members through 183 affiliated medical and dental centers located throughout the

Twin Cities area. The two plans are marketed together by a single sales staff. Buyers can choose either plan independently, or select both plans together.

As mentioned earlier, HealthPartners added a hospital to its portfolio by affiliating with Ramsey HealthCare, a key element for the creation of HealthPartners' own ISN. Under the agreement struck between the two organizations, Ramsey HealthCare was dissolved this summer and HealthPartners became the governing authority over St. Paul-Ramsey Medical Center, Ramsey Clinic, and the Ramsey Foundation in St. Paul. The organizations are in the process of integrating various operational programs. They also plan to work together to improve health care services and develop outcomes measurement systems.

Allina Health System

Allina, the result of the merger of Medica and HealthSpan, creates the largest integrated delivery system in the state. The merger was completed this summer, and together the two organizations have combined annual revenues of more than $1.8 billion. The intent of merging a payer (Medica) and a provider (HealthSpan) was to create a more accountable model organization, according to K. James Ehlen, M.D., president of Allina. "Health care consumers tell us they want to deal with a single organization they can hold fully accountable for providing appropriate care," says Ehlen, "and that they want that organization to carefully monitor quality and costs. By working closely with providers and aligning their incentives with those of the insurance component, we hope to reduce medical cost increases while continuing to improve the quality of the services we deliver."

Medica operates a statewide HMO with about 580,000 members. Allina has 17 hospitals, 45 medical clinics, and about 330 primary care physicians in its group practice organization. It also operates Select Care, a PPO that has about 290,000 members.

Half of Allina's board of directors comes from Medica, the other half from HealthSpan. A significant number of board members are physicians, and the chair of Allina's board is a practicing physician from the Medica board.

This summer, Allina formed a strategic partnership with MeritCare Health System, based in Fargo, North Dakota, to expand health care delivery and clinical care management in a 19-county area in northwestern Minnesota and North Dakota. The groups plan to further develop a regional integrated care network under the direction of an eight-member regional operating board with membership equally divided between MeritCare and Allina.

Allina plans to compete for business statewide by setting up a series of regional ISNs. "We won't be doing this with a single ISN run out of St. Paul," says

Twin Cities Children's Hospitals

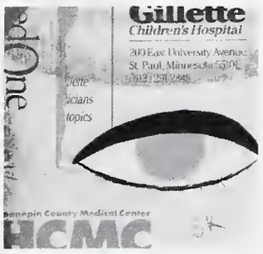
Like all local health care organizations, Twin Cities children's hospitals are searching for their niche, with some choosing to affiliate and some choosing to remain independent.

Minneapolis Children's Medical Center and Children's Hospital of St. Paul merged this June to form Children's Health Care. "There's considerable pressure on the entire health care industry to produce value, and merging puts us in a better position to increase quality and decrease costs," says Mary Haugen, a spokesperson for Children's Health Care. "If we didn't merge, our organizations may have been forced to join a larger organization whose focus is not on children." She says Children's Health Care plans to develop relationships with several ISNs—not just one—so more kids will have access to its services."

The 254-bed Children's Health Care includes the two hospitals, now called Children's-St. Paul and Children's-Minneapolis; a new ambulatory health services center in Minnetonka called Children's-West; a pediatric unit at Fairview Ridges called Children's-Ridges; and foundations serving both hospitals.

Other hospitals are choosing to remain independent. "It's not an issue with us," says Margaret Perryman, Gillette Children's chief executive officer, when asked about the possibility of a merger. Gillette Children's is a nonprofit hospital that specializes in children and adolescents with disabilities, including cerebral palsy, spina bifida, scoliosis and other complex orthopedic problems, arthritis, epilepsy, and brain injuries.

"We want our services to be available to every system in the state," says Perryman. "If we became part of a particular hospital group, we might lose our ability to serve every child. Therefore, our approach is to try to



Medica's Strand. In each community, Allina plans to involve community leaders and employers in the gov-ernance structure of the ISNs, as probably will be required by the new law.

Allina's physicians and hospitals contract with many of its HMO competitors—a situation that could lead some of those competitors to move patients away from Allina facilities. "That's a challenge when you try to create a vertically integrated system," says Strand. However, he doesn't expect it to be that big of an issue, and he doesn't anticipate significant changes. The other health plans need Allina, and Allina needs their contracts, he says.

Another priority for Allina is the creation of an administrative and clinical information system to link clinics, hospitals, and health plans within Allina and to assist care providers throughout the state with practice management. At the end of August, Allina announced its intent to purchase a controlling interest in StrategiCare, a Twin Cities-based developer and provider of medical practice management systems and administrative services. StrategiCare is the parent company of DISC Computer Systems, which provides practice management software and services, and EDI (electronic data interchange) networking to about 3,000 ambulatory health care providers.

Allina's intent is for linkage with DISC to allow physicians and other medical providers to exchange clinical information, such as patient care protocols, medical outcomes, and other patient-related data.

"The knowledge we gain through our new relationship with StrategiCare will help us communicate more effectively with all providers," says Gordon Sprenger, executive officer of Allina, "regardless of the type of practice management system they use."

Minnesota Blues ISNs

One of the most aggressive network developers has been Blue Cross and Blue Shield of Minnesota. With 1.2 million members, it's the largest health insurer in the state. Since the MinnesotaCare legislation went into effect, the Blues have assembled four new strategic joint ventures with providers that are each expected to become functioning ISNs under Minnesota's new law.

As the Minnesota Hospital Association says in one of its publications, "Blue Cross has steadily gone about filling its dance card for the big ... ISN start-up."

The moves by the insurer have been of keen interest to the state's hospitals, because Blue Cross has largely focused on creating ISNs that are physician driven rather than hospital driven. "We see the whole key to managed care programs starting with primary care physicians," explains Michael Morrow, the health plan's senior vice president of provider contracting and payment systems.

Blue Cross and Blue Shield of Minnesota is proving to be one of the more progressive Blue Cross and Blue Shield plans in the country. Along with its joint ventures with providers, the health plan is launching an electronic information highway that will allow hospitals, physicians, and other network participants to send and receive x-rays and other diagnostic images, order lab tests, exchange patient records, relay text and voice messages, and share outcomes information electronically.

The new computer network, called Minnesota MedCom, is a joint venture between Blue Cross and Integrated Medical Systems Inc. of Golden, Colorado. It's not exclusive to Blue Cross, but is open to all health care providers and payers in the state and border communities. Minnesota MedCom began rolling out the statewide network this year through pilot sites in five locations in the Twin Cities, St. Cloud, and Brainerd.

While Blue Cross has been making progressive moves, most of its 1.2 million members are still in indemnity plans. Its PPO has only about 186,000 members, and its HMO, known as Blue Plus, has about 110,000 members. But the organization has an aggressive strategy to link up with all the ISNs in the state."

The 40-bed Shriner's Hospital, located on East River Road in Minneapolis, is part of a national 22-hospital network that cares for patients with orthopedic problems. There is no precedent of any Shriner's hospital becoming part of another hospital system. All Shriner's hospitals provide free care, thanks to a $3.5 billion endowment.

As part of the University of Minnesota Health System's efforts to be more approachable, it changed the name of its children's hospital to University-Variety Hospital for Children, shortened to "U Kids." The new name is also intended to help distinguish the children's medical center from the University of Minnesota Hospital and Clinic, which shares the same space as U Kids, says Greg Hart, president of the University of Minnesota Health System.

reinvent itself as a managed care company, and its plans call for a four-pronged approach.

The joint ventures strategy is the first prong. The second and third prongs include converting PPO and HMO provider networks into ISN networks. The fourth prong will position BCBSM to act as a third-party administrator for other ISNs.

Not surprisingly, the BCBSM provider joint ventures are drawing the most attention. Each joint venture structure varies, depending on the specific market and the wishes and needs of the providers involved in the deal. Here's a closer look at how some of them are set up:

First Integrated Holding Co.

First Integrated Holding Co. is a joint venture between Blue Cross and HealthSystem Minnesota.

HealthSystem Minnesota was created last year by the merger of 426-bed Methodist Hospital and Park Nicollet Medical Center in Minneapolis. The two organizations have combined annual revenues of about $350 million. The creation of HealthSystem Minnesota was relatively pain free. Both providers were already nonprofit. Prior to the merger, the two organizations were very competitive with each other. Five years ago, for example, they each built their own cancer centers, located only six blocks apart.

"As an integrated health care delivery system, we will reduce these expensive capital outlays by eliminating duplicate services," says Park Nicollet's Migliori.

Park Nicollet, which launched MedCenters Health Plan in 1972, has been a managed care pioneer in Minnesota for more than 20 years. Currently, the medical group has about 150,000 patients in prepaid, capitated-style HMOs. It has 375 physicians who practice at 19 clinic sites in the Twin Cities area. The clinics have 160 primary care physicians and use a significant number of nurse practitioners and other nonphysician providers.

HealthSystem Minnesota, the parent company for Park Nicollet and Methodist, has a 25-member board. It includes 15 community leaders, representatives from Park Nicollet and from Methodist, administrative executives from HealthSystem Minnesota, and Methodist physicians who are not part of Park Nicollet.

First Integrated Holding Co., the joint venture between HealthSystem Minnesota and Blue Cross and Blue Shield, became active on September 1, 1993. The joint venture is governed by a four-member board consisting of two representatives from Blue Cross and one each from Methodist and Park Nicollet. HealthSystem Minnesota and BCBSM each made matching cash investments for a 50 percent equity position.

The joint venture's main purpose is to create a new managed care product to offer in the current market. The groups have set up an EPO, First Integrated Exclusive Provider Organization, which has signed up about 5,100 members, according to Migliori.

Pioneer Health Systems

In an effort to solidify a base in west-central and southwestern Minnesota, Blue Cross has also formed a joint venture with Affiliated Medical Centers, a for-profit multispecialty medical group based in Willmar, Minnesota. The joint venture, known as Pioneer Health Systems, Inc., will use as its hub Affiliated's 95 physicians who practice in eight locations in a 19-county area. The group includes about 60 primary care physicians. (For more information, see "Rural Reform: Communities Take the Initiative," July 1994 *Minnesota Medicine*, page 10.)

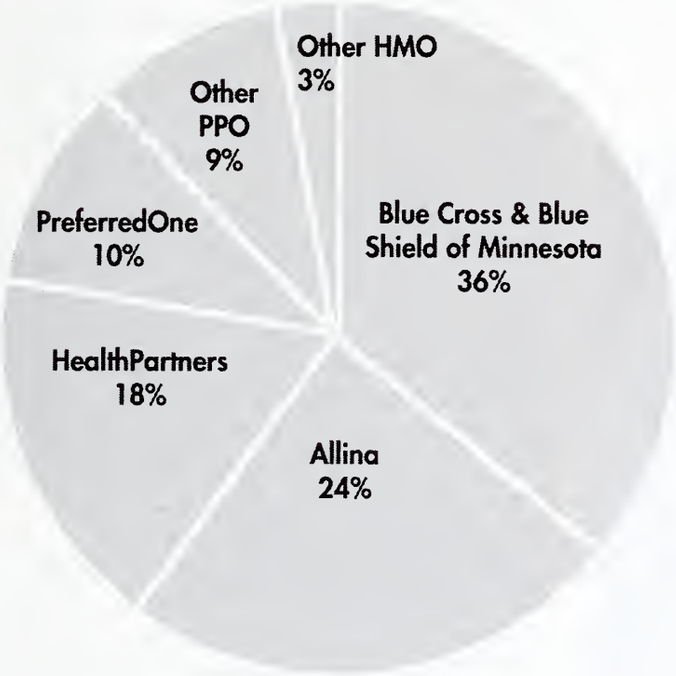
The first step in creating the joint venture was to develop Pioneer Health Systems Inc., which is a for-profit corporation, explains Edward Black, executive director of the new company. Each partner has a 50 percent ownership in the corporation.

The corporation is governed by a six-member board composed of three representatives from Affiliated and three from Blue Cross. It's initially functioning with a small staff consisting of Black, a medical director, and a secretary.

For legal reasons, Pioneer is being used as the development corporation for the creation of the eventual nonprofit CISN, which will be called New Pioneer Health Plan. However, the two partners expect the for-profit company to serve other functions. Blue Cross and Affiliated are considering using it as a vehicle to provide management consulting services to smaller medical clinics in the region that could use its sophisticated help, Black says.

New Pioneer, the nonprofit, has applied for licensure as a community integrated service network under the

1993 Market Share for Health Plan Companies



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new law, because it doesn't expect its enrollment to surpass the 50,000-member limit set for CISNs, Black says. That will give it more flexibility to operate. It will have its own governing board that will include 40 percent community representation as required by the CISN legislation. The balance of the board seats will include representatives from Blue Cross, Affiliated, and from hospitals in Affiliated's service area.

Blue Cross/Aspen/University of Minnesota/Fairview

Blue Cross laid the groundwork for a large-scale Twin Cities ISN in a joint venture established in July 1993 with Aspen Medical Group, a 150-provider multispecialty group that practices at nine St. Paul-area sites. In January this year, Blue Cross announced that the University of Minnesota Health System, Fairview Health System, and Fairview Physician Associates also are planning to join Aspen and Blue Cross in the joint venture. More additions to the group are predicted.

Blue Cross and Aspen, which is a nonprofit medical group with physician employees, set up a new nonprofit corporation known as Aspen Plus Health Network. Similar to the Affiliated joint venture, Aspen transferred its assets to the new company for its capital contribution to Aspen Plus Health Network, says Bill Riley, chief executive officer of Aspen Medical Group. Blue Cross contributed an equivalent cash amount for its 50 percent ownership in the venture.

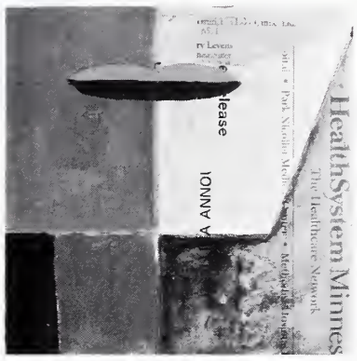
The nonprofit Aspen Medical Group has remained in place and continues to employ its physicians. It now leases its facilities from the newly created Aspen Plus Health Network, and it will eventually contract with Aspen Plus to treat patients that join the Aspen Plus Health Network, says Riley. Aspen Plus has a six-member board composed of three representatives from Aspen Medical Group and three from Blue Cross.

While the Pioneer joint venture plans to shy away from capitation, Aspen Plus will probably embrace it wholeheartedly, Riley says. "We prefer capitation. We're comfortable with it." About 80 percent of Aspen's 150 providers are primary care. The group already has about 60,000 capitated patients. Aspen Medical Group also hopes to use its new joint venture arrangement as an expansion platform. The network expects to have between 300 and 400 physicians within the next two years, Riley says.

While it's expected that the new agreement with the University of Minnesota Health System, Fairview Health System, and Fairview Physician Associates means that those organizations will join Blue Cross and Aspen's joint venture, it's still uncertain at this point how that will be achieved and how it will work, says Riley.

It's assumed that Aspen's 150 providers and Fairview Physician Associate's 585 physicians will serve as the primary and specialty care physician network for the ISN. The university's hospital, clinic, and its physicians will take care of specialty referrals that cannot be serviced by Aspen and Fairview. The new entries feel they have a lot to gain from the groundwork that's been laid by Blue Cross and Aspen.

"Aspen is a leading managed care organization whose experience will be invaluable to the partnership," says Richard Norling of Fairview Health System. "Blue Cross and Blue Shield of Minnesota has one of the largest systems in outcomes measurement in the country, an imperative if health care providers expect to be cost-



effective and quality driven."

The University of Minnesota Health System has been taking steps on its own in the past year to reinvent itself and prepare for the new world order. The teaching hospital sliced $40 million from its annual operating budget over the past two years. Those cuts included a painful $20 million reduction in the system's workforce. The hospital switched its employees from a public-sector benefits package to a private-sector benefits package and reduced full-time equivalent employees to 3,400, down from about 4,100. It cut another $15 million by refinancing debt, restructuring the hospital's malpractice program, and changing its use of medical supplies.

Fairview itself created a tighter affiliation with its physicians in June 1993, when Fairview Physician Associates (FPA) filed articles of incorporation as a nonprofit integrated practice network that is part of the Fairview Health System. The formation of this physician-hospital organization was a response to marketplace demands, including the Business Health Care Action Group's request for proposals. "Membership in FPA has been designed to allow physicians to meet market demands for a coordinated, comprehensive health care delivery system, while maintaining independence as small- to medium-sized practices," explains Robert Burmaster, M.D., president of FPA.

About 52 percent of Fairview's 585 physicians are primary care. All physicians in the organization have staff affiliation at one or more of Fairview's five hospitals. FPA has a 17-member board made up of seven physician representatives, eight community representatives, the chief executive officer of Fairview, and one clinic administrator. The seven physicians include Burmaster, four elected primary care physicians, and two elected specialists. Start-up funding and ongoing financial support for FPA has come from Fairview.

Norling says Fairview and FPA are interdependent, yet autonomous. "It is critical to Fairview that FPA be successful," he says. "However, Fairview is in no position to tell FPA what to do, or vice versa. Instead, the partnership we've formed allows us to build an integrated health system and pursue mutually agreeable patient service contracts."

Working toward building that system are FPA's four operating committees, co-chaired by a physician and a clinic administrator. They are developing products and payment methodologies, implementing a consistent patient satisfaction tool, identifying priority clinic-based pathways, and choosing an electronic medical record and information system to tie the network together.

FPA is not limiting itself to participation in any one ISN. It has been meeting regularly with various health plan representatives during the past six months. As *Minnesota Medicine* goes to press, FPA and Fairview have a letter of understanding with Medica to develop a long-term, collaborative relationship. In addition, discussions with PreferredOne are likely to prompt an announcement of some sort of affiliation early next year.

While Blue Cross has been emphasizing that its goal is to allow its joint venture partners in the ISNs to continue all other contractual relationships with payers, that may not work out exactly as they envision. As noted earlier, HealthPartners severed its ties with Aspen because of its deal with Blue Cross. Exclusivity will be one of the crucial issues as health care players in the Minnesota market set up their integrated systems and move toward tighter relationships. But not everyone believes that their futures lie with the big players.

Criterion HealthCare Network Inc.

One group that doesn't plan to merge with a big player is Criterion HealthCare Network, Inc. Criterion, headquartered in Minneapolis, is a physician-owned and governed "integrated clinic network" that includes about 600 independent physicians who practice throughout the greater metropolitan Twin Cities area. The multispecialty group consists of approximately 250 primary care physicians and 350 specialists.

Criterion provides its member medical practices with a vehicle to compete for patients with large multispecialty group practices prevalent in the Twin Cities. Each physician retains ownership of his or her practice assets but collaborates in such areas as the sharing of information concerning the cost, utilization,

and outcome of patient services, and in the setting of practice guidelines. The network approaches large purchasers, including HMOs and other health plans, concerning the possibility of establishing contracts to serve their enrollees.

"We, as independent practicing physicians, are being asked by purchasers of health care to demonstrate the value of the service we deliver and provide evidence showing how we plan to continually improve the quality of these services," explains Andrew J.K. Smith, M.D., a practicing neurosurgeon and chair of Criterion's 15-member board of directors. "More and more, savvy purchasers are demanding that we be accountable for both the cost-effectiveness and the outcomes of care provided," adds Smith, who is also current president of the Minnesota Medical Association.

Criterion was officially organized in 1994 and began seeing its first patients December 1 through a contract negotiated with Northwestern National Life Insurance Company. Through a separate administrative services agreement, an affiliate of NWNL will also provide information systems, claims processing, and other managed care support services to Criterion.

Criterion's 600 physicians primarily come from practices of fewer than 15 physicians, with an average clinic size of five physicians. Criterion is structured as a for-profit business corporation, according to Douglas A. Shaw, its executive director. The initial physicians joining the group each purchased one share of Criterion stock at a price-per-share of $750. The stock sale has raised about $450,000, which is being used to cover start-up expenses. According to Shaw, physicians joining Criterion after January 1 will be expected to pay at least $1,500 per share.

Physician partners in Criterion continue to be employed by their current practice entities, to own or lease their own practice facilities, and to employ directly necessary clinical and administrative support personnel. Through Criterion, however, these physicians are striving to integrate their practices in ways that optimize the delivery of high-quality, cost-effective care. Criterion provides member practices with certain shared management services, such as contract negotiation with third parties, coordinated efforts to continuously improve quality, and information systems strategies to electronically link Criterion offices.

Criterion physicians are willing to share risk through "global" fixed-price capitation contracts negotiated with health plans and others, and they believe they can compete successfully for patients by holding down overhead and focusing on efforts that combine the best patient outcomes with the optimal use of health resources. Smith says they "believe firmly that these results will best be accomplished by primary care physicians and referral specialists working in partnership with one another." As necessary, service contracts with hospitals and ancillary providers will be established.

In addition to the contract to serve NWNL enrollees, Criterion is holding discussions with other key health plans and buyer coalitions in the Twin Cities area. "There is strong interest by health plans and other purchasers in developing strategic, long-term partnerships with integrated clinic networks, such as Criterion, that carefully align incentives and build upon the core competencies of each partner," says Smith.

Criterion has also been carefully following health reform initiatives in Minnesota, including CISN legislation, which provides for a less costly approach to ISN development. Criterion might pursue such a strategy if it appears feasible and consistent with its business plan, Shaw says, adding that CISN development could be pursued independently, in concert with other physician networks, and/or in partnership with health plans.

Tracking the Criterion model and the efforts of similar physician-directed organizations is important, because it will probably be a good indicator of how well other more independent, less capitalized players can survive in a market where the big companies are powerful and dominant.

The real question, according to Fairview's Norling, is how fast the alignment of providers and payers will occur and how exclusive the relationships will be. His sense is that it's too early to tell at this point, but it appears payers are moving toward tighter relationships.

On behalf of Criterion and patients, Smith expresses the hope that "a new bottom line will emerge in the community—based not just on the lowest possible prices, but on a true demonstration that we are achieving the best outcomes with the most appropriate expenditure of our health care resources." MM

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The Group A Beta Hemolytic Streptococcus

No Longer Just a Nuisance?

Edward L. Kaplan, M.D.

History of Group A Strep

Forty or 50 years ago, infections caused by group A streptococci were common, and the associated morbidity and mortality were frequent and significant. Outbreaks of streptococcal infections included severe scarlet fever, suppurative sequelae such as sepsis, mastoiditis, and peritonsillar abscess, and nonsuppurative complications like acute rheumatic fever and acute post-streptococcal glomerulonephritis.

In the early 1940s, rheumatic fever and streptococcal infections were major public health problems in the United States. Thousands of cases of acute rheumatic fever occurred in the United States Navy alone. In 1955, in a *Minnesota Medicine* report, Fleming described incidence data for rheumatic fever for the state of Minnesota in the mid-1950s.[1] For the eight public health districts in the state, the incidence of rheumatic fever ranged from 60 to 100 per 100,000 population per year. These infections caused by the group A beta hemolytic streptococcus constituted a serious public health concern in Minnesota and elsewhere, and a great deal of effort was directed toward controlling the infections and understanding the pathogenesis of the sequelae.

Medical students and physicians in training spent considerable time mastering the diagnosis and management of these infections and the resulting complications. Organizations such as the American Heart Association undertook educational programs directed toward medical professionals and the public. In Minnesota, the state health department maintained a large rheumatic fever registry, which had as many as 13,000 rheumatic fever cases in its files at one time, and provided the penicillin for secondary rheumatic fever prophylaxis at no cost to patients.

In the early 1950s, the University of Minnesota Medical School attracted the attention of the national and international scientific and public health communities because of the important research into group A streptococcal infections and their sequelae carried out by scientists like Lewis W. Wannamaker, Robert A. Good, Lewis Thomas, and Floyd Denny. That tradition continues today, with numerous University of Minnesota clinicians and basic scientists in several departments studying this virulent organism and its consequences.

Rheumatic fever continued to be common in Minnesota and the United States even after World War II, but by the end of the 1960s, decreases in the severity of group A infections and in the incidence of their sequelae were evident. New cases of rheumatic fever were less common. Although this was frequently attributed to advances in medical care, antibiotics, or increased standards of living, the true reason(s) never became completely evident.[2] Because of this change in the epidemiology of group A infections, medical students were taught little about streptococcal infections and saw few patients with complications from such infections during their training.

Changes in Severity

Despite decreased complications, group A streptococcal upper respiratory tract infection has remained a major health problem among school children, and continues to be among the most frequent causes of sick child visits to primary care physicians.[3] But by the late 1970s and early 1980s, microbiologists and clinicians questioned whether these organisms were as virulent as they had been during previous decades. Less aggressive approaches to managing group A streptococcal upper respiratory tract infections were considered.[4]

In the mid-1980s, a discernible change in the severity of group A streptococcal infections and their sequelae occurred. Multiple outbreaks of acute rheumatic fever were reported around the United States.[5] Not only did severe group A streptococcal infections and their complications occur in children, but, as in earlier decades, outbreaks were reported at military training bases. The largest civilian outbreak occurred in Salt Lake City, where more than 270 cases of rheumatic fever were seen at the Primary Children's Hospital between 1985 and the end of 1992; the annual number of cases there is still high.[6] Ohio and several Eastern and Southern states were also affected.[5]

While the return of rheumatic fever was signaling a "resurgence" of more serious group A streptococcal infections, severe invasive group A streptococcal infections also began to attract notice. One of the largest early series was reported from the Western United States, where a fulminate group A streptococcal toxic shock-like syndrome was described by Stevens and colleagues in 1989.[7] Even with appropriate medical care, mortality as high as 30% was documented in the United States and in Western Europe.[7,8]

What appeared to be an increase of both suppurative and nonsuppurative sequelae of group A streptococcal infections generated renewed interest among clinicians and basic scientists. The reason for this increase in infections was not clear. However, it became apparent that more virulent strains and specific serotypes of group A streptococci were being isolated from ill patients in various parts

of the country and were temporally and geographically associated with the disease outbreaks.[9] Microbiologists, immunologists, and epidemiologists began to study clinical isolates of these organisms to determine what was responsible for this enhanced disease-causing potential. Differences among strains of the recovered organisms have been reported. Some data suggest that the strains associated with severe infections are now more likely to produce one or more of the pyrogenic exotoxins than were strains isolated in the recent past. Researchers have postulated that some extracellular products act as super-antigens that trigger the systemic reactions associated with the infections. However, we still have not identified the exact pathogenetic mechanisms that lead to the clinical sequelae, nor do we know how much is caused by the organism itself and how much is attributable to the human host response to the organism.

The outbreak in the mid- and late-1980s generated heavy publicity, as did the death of Jim Henson (creator of "The Muppets") from group A streptococcal invasive disease. Headlines in even the most respectable U.S. newspapers warned of the "deadly bacteria" before media coverage finally died down.

Interestingly, indirect epidemiologic evidence suggested that the number of cases may have actually decreased, although the number remained higher than the original baseline.[2,10] Since group A streptococcal infections are not reportable diseases in most states, including Minnesota,[11] accurate morbidity and mortality figures are difficult to ascertain. Nevertheless, in streptococcal reference laboratories, such as the one at the University of Minnesota, it has been apparent that these infections continue to be more common than during recent past decades (Kaplan EK, Johnson DR, Rehder C, unpublished observations, 1994).

In June 1994, exaggerated reports from the tabloid press in Great Britain featured stories of "flesh-eating" streptococci in front-page headlines, on radio and television talk shows, and in weekly news magazines, creating unnecessary fear. Much of the publicity generated by these severe systemic infections seemed aimed at selling newspapers rather than providing accurate facts and sound medical or public health advice to an alarmed populace.

Current Concerns

As we enter this year's streptococcal respiratory season, during the fall, winter, and early spring, physicians and public health authorities are attempting to determine the true status of these group A streptococcal infections. Because group A streptococcal infections and their complications are not reportable diseases in most states, public health data can be, at best, extrapolations. However, it is certain that we have seen a resurgence of streptococcal infections during the last five to seven years in Minnesota, in the United States, and in other parts of the world. Epidemiological data suggest that local outbreaks or clusters of infections, although rare, are sufficiently widespread so as to not represent epidemiologic artifacts. In community hospitals, streptococcal sepsis, necrotizing fasciitis, and streptococcal toxic shock-like syndrome also are being diagnosed with greater frequency than in the past. Although current evidence strongly suggests that these are still rare occurrences, reports of mortality as high as 30% are of significant concern. Particularly worrisome is the fact that the group A streptococcal toxic shock-like syndrome may first manifest by nonspecific flu-like symptoms, but within 24 to 36 hours, serious complications may have already occurred and death may result.[12] Thus, primary care physicians play a crucial role in diagnosing the infection.

The simultaneous increase in the suppurative and nonsuppurative sequelae of group A streptococcal infections with their differing pathogenetic mechanisms appears to be an epidemiological quirk. This resurgence has provided an unusual opportunity for the clinical and laboratory study of group A streptococcal infections and their complications. Comparison of current isolates with those from previous years can lead to new insights into the mechanisms for enhanced virulence. New techniques for investigating human susceptibility to these infections can now be utilized.

The resurgence of group A streptococcal infections and their sequelae has obvious implications for primary care physicians, who will have to pay careful attention to the diagnosis, as well as to antimicrobial therapy, of group A streptococcal upper respiratory tract infections. Utilization of the throat culture must once again be reemphasized in the management of children and adults with what appears to be clinically uncomplicated pharyngotonsillitis. Because of the recent development of new antimicrobial agents, physicians must give careful thought to optimal antibiotic therapy of these infections, keeping in mind both effectiveness and expense.

The public health implications also are obvious. Many of the outbreaks of group A streptococcal infections that have occurred during the last five to eight years have been recognized well after the peak of the outbreak simply because of a lack of consistent and reliable reporting by physicians. Perhaps required reporting of streptococcal infections and their sequelae would be beneficial and cost-effective.

Antimicrobial resistance is another important aspect to be considered. Erythromycin-resistant group A streptococci, while rarely reported in the United States,[13] has appeared in Finland and raises important questions about whether comprehensive surveillance of group A streptococcal isolates would be beneficial. The controversial issue of whether surveillance for group A streptococcal infections is cost-effective in schools is being debated again. Many people feel that schools are a logical location for monitoring and controlling these infections, and perhaps even preventing community spread. Although controversial for a number of medical and political reasons, this approach, especially in medically underserved populations, appears logical.

Finally, there is the need for research into the development of a safe, effective, and inexpensive group A streptococcal vaccine. Experience over the last five to 10 years in the United States demonstrates that anti-

biotics alone have not been effective in preventing outbreaks of group A streptococcal infections. Unlike *Haemophilus influenzae* type B, the theoretical and practical problems associated with developing a vaccine (or multiple vaccines) for group A streptococci are numerous. One single vaccine has proven to be effective against all strains of *H. influenzae* type B, whereas there are some 80 known (and many other as yet unidentified) serotypes of group A streptococci. Whether there are common antigenic determinants against which vaccines can be directed has yet to be clarified, either in animal studies or in human trials. If there is no common antigenic determinant, then we must ask whether a vaccine preventing group A streptococcal infection should be designed like that currently in use for *Streptococcus pneumoniae*. A number of the most common or "dangerous" serotypes necessarily would be included in the vaccine. A major problem with this approach for the group A streptococcus is the dynamic epidemiology—the ever-changing spectrum of different serotypes of group A streptococci moving in and out of a given community. Group A streptococcal vaccines might have to be tailor-made periodically for use in different communities—a potentially costly approach.

It seems strange that some 50 years after Rebecca Lancefield, Ph.D., pointed out the significance of group A streptococci in human disease and their connection with nonsuppurative sequelae, we still don't understand the pathogenetic mechanisms involved. Resolving these issues is important, not only because of the problems in the United States, but especially because of the impact of the group A streptococcus in many other countries. Rheumatic fever and rheumatic heart disease remain the most common cause of cardiovascular death in many developing countries[14]—areas that account for approximately two-thirds of the world's population.

The resurgence of group A streptococcal infections has vividly demonstrated not only the need for heightened awareness and improved clinical diagnosis and management, but also the need for clinical and laboratory research studies to assist in better understanding these infections and their sequelae. Each approach can contribute to improving health among children and adults worldwide. MM

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Youth Addiction to Tobacco

Physicians can help reduce smoking among youth by reaching patients at an early age and by being active in policymaking.

Thomas E. Kottke, M.D., Frances J. Mantak, and Leif I. Solberg, M.D.

Editor's Note: *As parents, grandparents, physicians, and community leaders, we strive to protect our children and youth from harm. The job becomes more difficult when the danger is glamorized by a $5.3 billion annual advertising campaign and the harm is delayed by years or decades. Using tobacco is deadly. The MMA at its recent Annual Meeting supported the current Minnesota lawsuit that asks for the tobacco companies to be held accountable, not for selling tobacco, but for withholding their research evidence of death, disease, and addiction from the American medical community and the American people. This month's public health article provides avenues for every physician to become involved in blocking the spread of this tobacco epidemic to our children.*

–Barbara P. Yawn, M.D., M.Sc., Series Editor

Figure 1—As it has become recognized that few individuals will start smoking after age 20, models for smoking have become more youthful.

Early initiation of tobacco use leads to lifetime addiction.[1] The Institute of Medicine, in a recently released report, has determined that "in the long run tobacco use can be most efficiently reduced through a youth-centered policy aimed at preventing children and adolescents from initiating tobacco use."[1]

There are significant warning signs that tobacco companies are maintaining tobacco addiction in our society by targeting youth and ensuring that a segment of the adult population remains addicted. Since 1980, daily tobacco use among high school students has not declined.[2] According to the 1992 Minnesota Student Survey, 22% of high school seniors use tobacco daily, a percentage unchanged from three years earlier.[3] This figure is almost identical to the 22.5% of Minnesota adults who smoked in 1993 (Minnesota Department of Health, unpublished data). The average age of initiation of tobacco use is 14.5 years.[4]

Why haven't we solved what former Surgeon General C. Everett Koop has called "the single most preventable cause of death and disease in this country"? Among the reasons are these: 1) physicians continue to miss clinical opportunities to advise their patients to quit smoking or never start, 2) society does not recognize the culpability of tobacco companies who recruit youth when supposedly aiming their advertisements at adults, and 3) society does not treat sales to youth as a serious problem. Major initiatives in Minnesota are making a tobacco-free community possible, and physicians play an integral part in the success of these efforts.

Clinical Opportunities

Even though physicians recognize that smoking is a serious risk to health, they frequently miss opportunities to help their patients quit smoking. Fiore has offered one solution, which is to make tobacco use a vital sign.[5] It has been clearly documented that simply asking patients whether they smoke will result in sustained cessation for a significant minority.[6] The National Cancer Institute has suggested that physicians think of smoking intervention in terms of four A's[7]:

- Ask about smoking;
- Advise patients who don't smoke to never start, those who do smoke to stop, and all patients to find avenues to reduce exposure to environmental tobacco smoke;
- Assist those who want help;
- Arrange for follow-up: a phone call or a "pat on the

back" for steps taken toward abstinence is highly motivating for those who use any form of tobacco.

The younger the age at which smoking is initiated, the greater the risk of heavy smoking later in life.[8,9] Physicians can prevent or delay the initiation of tobacco use, at least by helping the parents of their pediatric patients to quit. It is important to remember that tobacco use must be addressed early and often. Because the peak age of onset is the seventh grade, and many children start to experiment before this time, tobacco cessation counseling ought to start no later than the preschool physical at age 4 to 6 years. Considering that Joe Camel and Mickey Mouse are equally recognizable to 6-year-olds,[10] there is little chance that asking young children about smoking is introducing an idea that has not yet occurred to them. Even young children need age-appropriate messages from their physicians that reinforce a tobacco-free norm or provide encouragement to quit.

Strategies to Change Community Norms

State-of-the-art education programs and prevention strategies have been developed and implemented in this state. Yet, without a comprehensive community tobacco control program, they simply do not work.[11] Education alone is not enough to counteract the community environment in which aggressive advertising, intense promotion, and easy access target our children.

Tobacco advertising and promotion

The tobacco industry spent $5.23 billion on advertising and promotion in 1992, an increase of 12.5% from 1991.[12] Tobacco industry marketing expenditures have increased more than 100% in the past five years, making cigarettes the second most promoted consumer product in the United States.[4,12] While the tobacco companies claim they are encouraging adults who smoke to switch brands, each year they recruit millions of new young smokers.[1]

Adolescents consistently smoke the most heavily advertised brands of cigarettes, both in the United States and other parts of the world.[13-15] DiFranza et al.[15] found that 94% of high school students recognize the Joe Camel cartoon character, as opposed to only 58% of adults. Since the start of the Joe Camel campaign, Camel's share of the illegal children's cigarette market has increased from 0.5% to 32.8%.[15]

Few smokers start after they have reached legal age, and modern cigarette advertisements often feature youthful models (see Figure 1). Among girls under 18, smoking initiation increased abruptly around 1967, when Virginia Slims, Silva Thins, and Eve cigarettes were introduced[16] (see Figure 2). Adolescent females' smoking nearly doubled between 1968 and 1974 (from 8% to 15%).[17] Following a major advertising and promotional campaign in the 1970s that targeted "beginners," a similar increase was seen for smokeless tobacco use among male adolescents.[18]

In 1985, the Minnesota Department of Health initiated a counter-advertising program that was funded through the tobacco excise tax. In 1991, the tobacco tax money designated for the program was allocated to the general fund, and appropriations for counter-advertising were reduced and then eliminated in 1993. A similar program in California was associated with a 27% additional decline in cigarette sales (see Figure 3).

Youth access to tobacco

Along with being bombarded with tobacco promotion every day, Minnesota youth have easy access to tobacco products. Studies in Minnesota communities have shown that youth can easily purchase tobacco over the counter (84% of girls and 59% of boys who try to buy cigarettes succeed); and, if denied an over-the-counter sale, youth can usually obtain tobacco from vending machines (89% of girls and 75% of boys).[19-20]

The most effective way to prevent tobacco sales to minors is to target and hold the merchants accountable. Selling tobacco is a licensed privilege, not a right. City councils need to revoke the licenses of vendors who repeatedly sell to youth. Businesses can also take action.

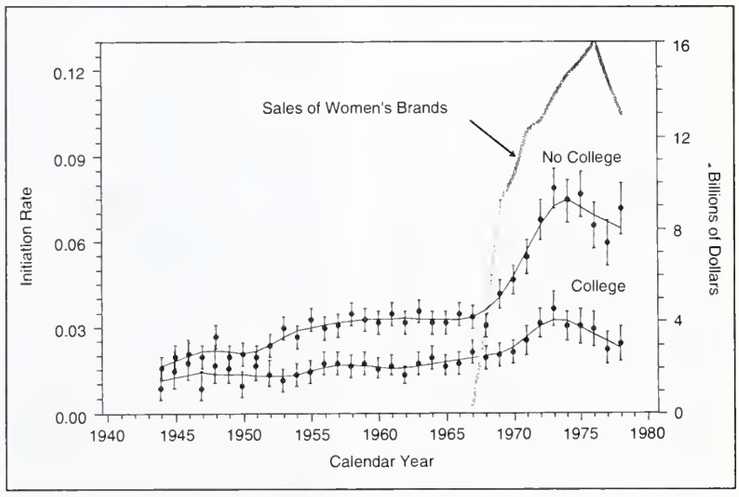

Figure 2—Products and ad campaigns featuring young women have been associated with a marked rise in smoking rates among adolescent girls. (Reprinted with permission from Pierce JP, Lee L, Gilpin EA. Smoking initiation by adolescent girls, 1944 through 1988. JAMA 1994;271:610.)

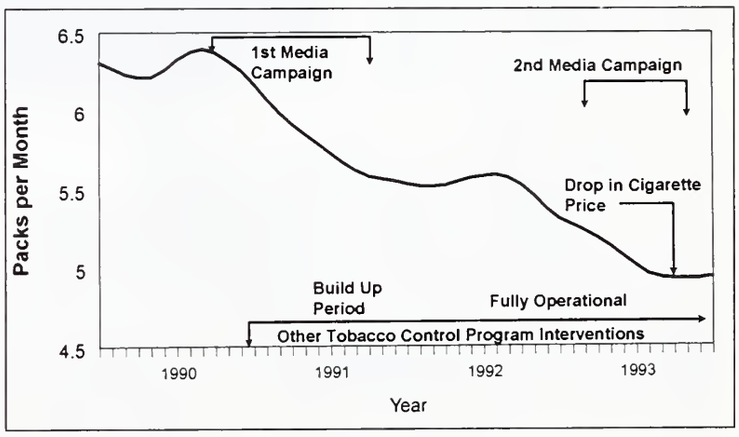

Figure 3—Per capita consumption of cigarettes in California. Each of two media counter-advertising programs in the state was associated with a 12% decline in tobacco sales. (Reprinted with permission from Pierce JP, Evans N, Farkas AJ, et al. Tobacco use in California: an evaluation of the Tobacco Control Program, 1989-1993. La Jolla, California: University of California, San Diego, 1994.)

SuperAmerica stores have developed an effective self-monitoring system for their sales team. Physicians can help demand that such systems become an industry standard.

Tobacco excise tax

Youth are highly price-sensitive when it comes to purchasing tobacco.[21] Significant increases in the tobacco excise tax are the single most important strategy currently available to reduce consumption and prevent youth from starting to smoke. Contrary to what the tobacco companies would like us to believe, tax as a portion of purchase price has dropped from 50% in 1964 to 25% of the cost of a pack of cigarettes today.[22] Over the past few years, financial support for tobacco control programs at the Minnesota Department of Health, at times funded directly by the tobacco excise tax, has also declined sharply.

Strong community action is needed to combat the powerful impact of tobacco advertising and promotion and the ease with which youth can obtain tobacco. Restricting advertising and promotion, actively monitoring merchant sales to youth, and advocating for an increase in the tobacco excise tax can do much to stop youth addiction. Physicians can actively support these policies and, through minimal commitment, promote the community's health.

Resources for the Physician

Growing Up Tobacco Free: Preventing Nicotine Addiction in Children and Youths
Institute of Medicine Report
Call the National Academy Press, 800/624-6242

How to Help Your Patients Stop Smoking: A National Cancer Institute Manual for Physicians
Call the Cancer Information Service, 800/4-CANCER

American Academy of Family Physicians Stop Smoking Kit
Call the American Academy of Family Physicians, 800/944-0000

Physicians may also contact the following organizations for information:

Minnesota ASSIST Project
c/o Minnesota Department of Health
Post Office Box 9441
717 Delaware Street SE
Minneapolis, Minnesota 55440-9441
or call Cari Bucher, 612/623-5304

Minnesota Coalition for a
Smoke-Free Society 2000
420 North Fifth Street, Suite 525
Minneapolis, Minnesota 55401
612/338-8193

A Tobacco Company Conspiracy?

Recently, co-plaintiffs Blue Cross and Blue Shield of Minnesota and the Minnesota attorney general took a bold step by suing the tobacco industry for conspiracy, fraud, and antitrust. A news release issued August 17 by the attorney general's office said they are alleging that "the cigarette companies and their trade associations broke their public promise to disclose to the American people the truth about smoking and health and have united in a four-decade conspiracy to cover up their knowledge about the addictive and lethal qualities of cigarettes."

Physicians need to support this action publicly. Let the attorney general and Blue Cross and Blue Shield of Minnesota know that you support their efforts. Write to your local newspaper to let your patients and local elected officials know that you support the suit. If a particular firm provides your legal services and also provides counsel to tobacco companies, let them know that you consider this an inappropriate conflict of interest.

In addition to supporting the attorney general's efforts, physicians can get involved through several other avenues. Support community coalitions and state organizations such as the Association for Non-Smokers' Minnesota (ANSR), the American Cancer Society, the American Lung Association, and the American Heart Association. Another such group is the Minnesota Coalition for a Smoke-Free Society 2000. For the past decade, this coalition has worked collaboratively with many organizations and has successfully supported legislation to eliminate smoking in hospitals and schools and to make important changes to the Minnesota Clean Indoor Air Act. The Robert Wood Johnson Foundation funded the Smoke-Free 2000 Coalition to help support an increase in the tobacco excise tax as a means of reducing tobacco consumption. The group needs physicians to ask their local and state representatives to support tobacco control programs.

Finally, the Minnesota ASSIST Project is a partnership between the Minnesota Department of Health, the American Cancer Society, and the communities in this state. Its goal is to reduce tobacco use to 15% of Minnesota's population by the year 2000 through changes in public policy. Physician involvement with ASSIST's community coalitions can lead to significant changes in local and state policies. Contact the ASSIST project (see sidebar above) for local contacts and further information. Letter writing and public speaking are simple but effective means through which physicians can show their support for all these efforts.

Conclusion

Youth smoking, associated with aggressive marketing programs, has remained constant for a generation. If we

are to prevent an epidemic of tobacco-related disease in the next generation, each physician needs to advise patients to abstain from tobacco use and needs to support community-based efforts to limit sales and promotion to youth. MM

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The Monitor
News For Minnesota Physicians

Announcements

MMA Will Convene Special Session of MMA House of Delegates

The MMA House of Delegates will convene on January 7, 1995, at the Northland Inn in Brooklyn Park to consider the MMA bill, the Minnesota Health Care Quality and Coverage Act.

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MMA Seeks Member Input into MMA Bill

The MMA is moving very quickly to develop a comprehensive legislative proposal. The MMA Board has approved a framework for the bill, which is summarized on pages 33 to 35 of *The Monitor*. Some key decisions, however, will not be made until the next board meeting on December 17. The MMA proposal will be drafted into legislative language, presented again to the board, and finally to the House of Delegates.

The MMA has launched an extensive Legislative Outreach effort and is convening focus groups to seek members' input into the MMA bill. Focus groups are being held in the Twin Cities, St. Cloud, Duluth, and Brainerd. Legislative Outreach meetings are scheduled in Brainerd, Rochester, St. Cloud, New Prague, and Albert Lea. An extra issue of *The Monitor In Brief* was published in November and another will be published in December to keep members informed about the rapid development of the MMA legislation and to ask for members' opinions. *The Monitor In Brief* is usually published January to June.

MMA Board Approves Content of Quality and Coverage Act

The Minnesota Medical Association will introduce a health system reform bill called the Minnesota Health Care Quality and Coverage Act during the 1995 legislative session. This proposal is designed to move the state closer to the goal of universal coverage and to regulate a level playing field on which many different kinds of health plans can compete. It would repeal the regulated all-payer option (RAPO) and allow HMOs, integrated service networks (ISNs), community integrated service networks (CISNs), co-ops, indemnity plans, and physician-directed networks to flourish. The MinnesotaCare program would be funded by a broad-based tax instead of the 2 percent provider tax. The goals are universal coverage, affordability, and continuous quality improvement.

On November 19, the MMA Board of Trustees approved the contents of the legislative proposal but saved some decisions for the next meeting. The Quality and Coverage Act will be drafted into legislative language and submitted to the MMA Board of Trustees on December 17. The MMA House of Delegates will convene January 7 to consider the bill. A summary of the main points of the bill follows.

Universal Coverage

Insurance reforms and cost-containment efforts will only succeed if everyone has health care coverage. People who can afford to pay for insurance should do so; those who can't afford coverage should receive subsidies on a sliding scale from the state.

Enforce the Mandate

The 1994 MinnesotaCare legislation requires every Minnesotan to have health care coverage by 1997 if the MinnesotaCare program is adequately funded by that time. But the law provides no way to enforce this mandate. The MMA may propose enforcing the insurance requirement through tax policy. Any person or family that didn't have the minimum amount of coverage would not qualify for the personal deduction on the state income tax form, a loss of $2,000 per dependent. A decision on this proposal was delayed until the December board meeting.

Provide Broad-based Funding

The amount of money needed to ensure universal coverage is still unknown. It will depend in part on the universal standard benefits set, which has yet to be determined, but the MMA estimates that approximately $100 million to $400 million would be sufficient to expand the MinnesotaCare program. The MMA Board set aside a decision on the funding source until its December 17 meeting. The following possibilities are under consideration:

- Repeal the 2 percent tax on health care services. This tax is inadequate, difficult to administer, and places an unfair burden on the sick.
- Increase the excise tax on cigarettes by 40 cents per year for five years. The current tax is 48 cents per

Act continued on page 34

Act continued from page 33

pack. This tax would generate approximately $100 million in the first year and nearly $500 million at the end of five years.

• Increase the excise taxes on alcoholic beverages to raise approximately $37 million.

• Expand the sales tax.

• Add a new income tax bracket to be taxed at 10 percent to raise about $112 million per year, adjusted for inflation. Current income tax rates are 6 percent, 8 percent, and 8.5 percent. This proposal would add a 10 percent rate for a married couple, filing jointly, whose income was more than $103,050 and for an individual earning more than $58,290.

Propose Insurance Reforms

Currently, MinnesotaCare law calls for pure community rating by 1997. The MMA bill may replace this with modified community rating adjusted by age. This would reduce the financial impact on young people and help ensure that they comply with the mandate. The MMA may also propose a ban on denial of insurance coverage to victims of domestic violence. These decisions were deferred until the December meeting.

Affordability

If health care is to be affordable, all stakeholders must be held accountable for controlling excessive cost increases. The MMA believes this can best be accomplished by encouraging competition among many different health plans and by giving the purchaser more power in the marketplace. The MMA will propose ways to encourage cost containment through a competitive marketplace and malpractice reform.

Repeal the Regulated All-Payer Option

The MMA bill will call for repeal of the RAPO provision.

• Repeal the current MinnesotaCare law requiring that after July 1, 1997, all health care that is not delivered through ISNs or CISNs must be delivered through RAPO. Originally, this provision was designed to encourage the formation of ISNs and to contain costs in the fee-for-service market. Since networks have already formed throughout much of the state, the implementation of RAPO is unnecessary and would direct money needed to fund the MinnesotaCare program toward administration of a new regulatory system.

• Repeal RAPO language permitting the development of a statewide fee schedule.

• Maintain only until 1997 the 10 percent limit on revenue and expense increases for providers and health plans. After 1997, the state will have moved much closer to the goal of universal coverage and health plans, regulated by similar standards, will compete in the marketplace. At this point, the desire to be competitive will control costs so the growth limits will not be necessary.

Set Standard Health Plan Regulations

The MMA will propose standard regulatory requirements for all health plans, including HMOs, ISNs, CISNs, co-ops, and indemnity insurance companies. For the competitive market to work, there must be a more standardized product that purchasers can compare on the basis of cost, choice, access, and consumer satisfaction.

The MMA will propose that the Recodification Task Force, which recently convened to consider ISN and RAPO regulations, should develop uniform standards for all health plans, which would include the following:

• A universal standard benefits set that could be offered with several different cost-sharing options, such as copayments and deductibles. Plans could offer supplemental benefits in addition to the standard set.

• Insurance reforms, including those slated to take effect July 1, 1997;

• Data reporting and health plan report card provisions;

• Appropriate solvency and reserve requirements;

• Use of a risk-based capital mechanism;

• Participation in the Minnesota Comprehensive Health Association and in the risk-adjustment association that is being developed; and

• Patient protection requirements.

Encourage Purchasing Pools

As an alternative to RAPO, the MMA envisions that small employers and individual purchasers will pool together so they have more bargaining clout. Alone, small players have no power to affect price or quality. Together, they will be able to make better deals with health plans and offer their members cheaper premiums and greater choice. The 1994 MinnesotaCare Act allows employers, groups, and individuals to form purchasing pools "solely for the purpose of negotiating and purchasing health plan coverage." The participants must live in the same region of the state, have similar occupations, or share some other common factor. These limits are intended to prevent pools from cherry picking healthy enrollees. The MMA may propose that purchasing pools be required to offer a range of different types of plans.

Reform Professional Liability Law

The MMA bill will include the following reforms based on the California Medical Injury Compensation Reform Act (MICRA):

• Cap non-economic damage awards at $250,000;

• Repeal requirement that the plaintiff's attorney receive 15-day notification before the physician/defendant can consult with the defense attorney;

• Reform joint and several liability laws;

• Set sliding-scale cap on attorney contingency fees related to the size of the award;

• Require periodic payments for large awards; and

• Mandate offsets for collateral payment sources to prevent double recovery from insurance or other sources and then from a malpractice award.

Propose Antitrust Protections

The MMA will consider the possibility of seeking state antitrust protection for collective bargaining by physicians dealing with large health plans. The MinnesotaCare law already includes sufficient state protection for physicians who form networks. Although the main stumbling block is federal antitrust law, the MMA will explore ways to protect collective bargaining as much as possible through state law. This issue will be studied and discussed again in December.

Quality Improvement

Health care quality in Minnesota has consistently been high while costs have ranked among the lowest in the nation. The MMA will propose ways to maintain this high quality as cost pressures continue to mount, and will propose ways to improve choice for physicians and patients. Providing buyers with more information about health plans will empower them to make smart purchasing decisions. The educational use of data, practice parameters, and technology assessments will give physicians and other providers the information they need to continue improving quality of care.

Preserve Choice and Quality

• Require all health plans to offer a point-of-service option that would allow people to seek medical care from any health care providers regardless of whether they are in the plan network and regardless of specialty. Health plans would be required to offer a point-of-service product or fee-for-service alternative as a choice for individual purchasers in all segments of the market—large group, small group, and individual—during the open enrollment period.

• Forbid health plans to design their provider network, their policies on access to providers, or their marketing strategies in a way that would discourage the enrollment of high-risk patients. Provider networks should not be allowed to omit or significantly underrepresent providers who specialize in caring for patients with expensive chronic conditions or whose practices focus on ethnic minorities. Violations should be enforced as unfair trade practices by the Department of Commerce or the Department of Health.

• Ban health plan/provider agreements that directly require the provider to withhold or deny care or to refuse to make an appropriate referral in exchange for financial rewards. This provision would not prohibit capitation or other compensation methods that serve to hold providers financially accountable for the cost of caring for a patient population.

• Require health plans to pay for bona fide emergency care for enrollees even if care is provided outside the health plan's network. The plan could require the patient to be transferred to a network hospital as soon as medically possible.

• Require health plans to participate in the financial risk-adjustment system being developed by the state.

• Refine Minnesota's utilization review laws to make sure that utilization review is not used to prevent patients from receiving medically necessary services.

Require Health Plans to Disclose Information

Health plans should be required to disclose the following information in their action plans, in addition to the data required by the 1994 legislation:

• A description of utilization review practices and policies;

• A list of any types of providers or services that enrollees can use only if they are referred by another provider, a description of the types of providers authorized to act in this role of gatekeeper, and a description of the policies governing referrals;

• A description of the role of patients and health care providers in governing and operating the health plan, including the role of actively practicing providers in determining the health plan's medical policies; and

• A description of how the health plan's provider network design, its policies on access to providers, and its marketing strategies address and do not discourage enrollment and access to care for high-risk and special-needs enrollees.

Current law requires plans to provide information about credentialling, the number and type of network providers, and policies to address the needs of high-risk and special-needs patients.

Improve Provider Quality

The MMA believes that data initiatives should be used for provider education and continuous quality improvement rather than for cost containment. Coordination and communication among the various state entities dealing with data should be improved. The MMA bill will propose that the Minnesota Health Data Institute (MHDI) establish the policies for data collection, analysis, confidentiality, and disclosure for all data not associated with the public health initiatives of the Minnesota Department of Health (MDH). The MDH would deal with public health data and growth limit data, and the MHDI would be responsible for data related to quality, outcomes, and patient satisfaction. The MHDI would remain a public-private partnership of the state, providers, payers, and purchasers. The Practice Parameter Advisory Committee, the Health Technology Advisory Committee, the Health Data Analysis Unit, and the Information Clearinghouse would be under the auspices of the MHDI. The MMA will also draft legislation that will ensure that the law provides adequate protection from inappropriate disclosure of data.

The MMA wants to hear from all members. Please fill out the survey in the November issue of *The Monitor In Brief*, call and leave a message on the toll-free DIAL MMA hotline (800/342-5662), or talk to an MMA trustee, delegate, or officer.

The draft framework for an MMA bill is subject to change based on the reactions of MMA members, further discussion by the MMA Board of Trustees, and decisions by the MMA House of Delegates.

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Viewpoint

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Timothy J. Crimmins, M.D.
Chair, MMA Board of Trustees

Physician Frustration Leads to MMA Reform Bill

We physicians are frustrated about the direction health system reform is going in Minnesota. The government is moving toward an overly regulatory system while the private market is consolidating into a few powerful players. As a result, we are in danger of losing the ability to do what's best for our patients.

The MMA bill would put health system reform back on the right track. The Quality and Coverage Act would create a fair, competitive marketplace that holds down costs without excessive regulation. It would help preserve physician autonomy, maintain quality, and move the state closer to health care coverage for all Minnesotans.

Minnesota has not reduced the number of uninsured, which has remained fairly steady at about 400,000 since 1990. So far the state has focused on controlling costs through regulations that put a burden on physicians, particularly those in small practices.

We are frustrated by the time-consuming and expensive reporting requirements, the tightening limits on our fee or revenue increases, the limits on Medicare balance billing, and the proposed fee schedule for the regulated all-payer option (RAPO).

In the marketplace, there has been a series of mergers that leaves physicians with little power. Employers are forming large purchasing groups; insurers are merging into a few giant health plans; and providers are being drawn into networks. Some physicians would prefer to stay independent, but fear they'll be locked out of the market by the big players.

Physicians chafe under the micromanagement of managed care and resent the amount of paperwork required. We fear that so much emphasis on cutting costs could rob us of the power to provide high-quality, necessary care for our patients.

The MMA Quality and Coverage Act envisions a new model for Minnesota. The state would make sure that all players had a fair chance to compete, then let the market work.

Under the MMA model, the state would set a level playing field on which many different entities would compete. There would be HMOs, co-ops, physician-directed plans such as clinics without walls, PHOs, and indemnity plans, as well as CISNs and ISNs. Local initiatives would be encouraged. All plans would be required to offer a universal standard benefits set with a number of cost-sharing options and would have to follow the same regulations.

The power of the purchaser would be strengthened. Buyers would compare similar products on the basis of access, cost, choice, and consumer satisfaction. They would know who belongs to the networks, how plans select physicians and other providers for the networks, the limitations on choice, the copays and deductibles. Small employers and individuals would belong to purchasing pools so they could negotiate better prices and more choice. Competition in the marketplace would hold down costs so there would be no need for RAPO. RAPO would be repealed.

This competitive model will only work, however, if there is universal coverage, or a very strong move in that direction. In a competitive model, there's not much room for cost shifting of care for the uninsured. Hospitals and clinics that treat a disproportionate number of the uninsured would be at a tremendous disadvantage.

There must be a means to enforce the law that everyone have health care coverage by 1997. Many of the uninsured can afford insurance but don't think they'll get sick, so they spend their money in other ways. If they do get sick, the provider ends up with a bad debt. Putting teeth in the mandate will reduce the number of uninsured. People who can't afford insurance should receive government help so the cost of their care doesn't fall on a hospital or clinic that is trying to compete.

The state may never achieve 100 percent coverage, any more than it will achieve a smoke-free society or a violence-free society. But if we want a competitive rather than a regulatory system, we must push for as much coverage as possible. We will have to make hard decisions. Nobody likes taxes. But they are necessary to achieve universal coverage. And coverage is the cornerstone of a fair, competitive model that would replace regulations, fee schedules, and growth limits. The MMA will call for a repeal of the 2 percent tax and enactment of a broad-based tax.

Do you agree with the MMA model for a fair, competitive system? Let us know. Strong member support is essential.

ANNOUNCEMENTS

New Medicare Balance Billing Limits Take Effect

Beginning January 1, 1995, non-participating health care providers cannot charge a Medicare patient who is a Minnesota resident more than 105 percent of the non-participating Medicare-approved amount for any Medicare-covered service. This is a drop from the 110 percent billing limit in 1994. In January 1996, balance billing to Minnesota residents will be banned.

The state balance billing limit, set by the 1992 MinnesotaCare legislation, is lower than the federal limiting charge of 115 percent. This could cause confusion. The two Medicare carriers in Minnesota—Travelers and Blue Cross and Blue Shield—administer the federal Medicare program, but not the state limits. Therefore, they will continue to refer to the federal 115 percent limiting charge rather than to Minnesota's 105 percent limit.

The Minnesota Department of Health expects providers to comply voluntarily with the law. MDH staff have indicated that if they become aware of violations, they plan to enforce the limit.

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Data Collection Survey Is on the Way

The Minnesota Department of Health (MDH) plans to mail every clinic a data collection survey asking for 1994 revenue and expenditure data. Last year the state only asked 700 of the larger clinics for this information, but now small clinics and solo practices must respond as well. Although the final data collection rules have not been adopted, MDH plans to mail the reporting forms in mid- to late December 1994. The completed form must be returned to MDH by April 1, 1995.

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State Estimates Growth Limit

Minnesota's estimated growth limit for 1995 is an 8.3 percent increase in 1994 health care provider fees or revenues.

Beginning January 1, 1995, all health care providers will be subject to the projected 8.3 percent increase, based on revenue per patient, revenue per encounter, or a limit on each fee. Providers must keep records in case of an audit. The actual growth limit, which is based on the consumer price index, will be announced January 31, 1995.

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MMA and MMGMA Testify on MMIS II Problems

The Minnesota Medical Association and the Minnesota Medical Group Management Association (MMGMA) worked together to develop testimony on problems with the Minnesota Medicaid Management Information System (MMIS II), the electronic system for submitting claims for Medical Assistance, General Assistance Medical Care, and MinnesotaCare. After MMIS II was introduced in May 1994, clinic managers reported problems, including long delays in bills being paid. On November 14, Ric Davenport, a clinic manager, testified for the MMA and the MMGMA before the Senate Health Care Committee's Health Care and Family Services Finance Division, chaired by Sen. Don Samuelson, DFL-Brainerd.

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MMA Will Develop Bill to Address BMP Issues

The MMA Board of Trustees on November 5 gave a green light to a proposal that the MMA Committee on Ethics and Medical-Legal Affairs begin drafting a bill to address various Board of Medical Practice (BMP) issues. The committee will bring the proposed legislation back to the Board of Trustees for approval. Among the many issues to be addressed, the bill may propose that consultant reports and corrective action agreements be classified as private, and that there be a statute of limitations for BMP disciplinary actions. The MMA plans to introduce a BMP-issues bill during the 1995 legislative session.

MEDPAC Was Successful in the '94 Elections

• • • • • All the candidates MEDPAC endorsed for the U.S. House of Representatives won in 1994. The MEDPAC-endorsed candidates for governor and for the U.S. Senate were also successful.

In elections for the Minnesota House of Representatives, 88 percent of the MEDPAC-endorsed candidates won. MEDPAC endorsed candidates for 69 of the 134 House seats up for election. Of those 69 candidates, 61 won their races. MMA physician Richard Mulder, M.D., the IR challenger in District 21B, was successful. Two MMA spouses also won: Ron Abrams, IR, in 45A, and Peggy Leppik, IR, in 45B. There will be 26 first-termers in the House in 1995. In the two Senate races, MEDPAC endorsed both of the winning candidates: Mark Ourada, IR, in District 19, and Kenric Scheevel, IR, in 31.

MEDICARE NEWS

AMA President Predicts Medicare Cuts

In an address to the MMA Board of Trustees, Robert E. McAfee, M.D., president of the AMA, predicted Medicare Part B will be a target for cuts in 1995 because lawmakers want to take this unpopular step in a non-election year. Originally proposed as part of various health system reform bills, the Medicare cuts will probably be put forth in 1995 as a way to reduce the federal deficit, according to McAfee. The AMA will oppose Medicare cuts and will continue to tell Congress that Medicare coverage should be based on need. McAfee said he didn't think a young family with children, scraping by on a moderate salary, should be paying to subsidize Medicare coverage for Lee Iacocca.

OIG Targets Drug Marketing Practices

Following an investigation into Hoffman-LaRoche's prescription drug marketing practices by the Department of Health and Human Services and the Department of Justice, the New Jersey company agreed to a $450,000 civil and administrative settlement. The firm offers a "grant-in-aid" program giving physicians grants for conducting studies of its antibiotic Rocephin. The investigation found that many physicians were selected for their ability to recommend Hoffman-LaRoche drugs to other physicians or to include them on hospital formularies. The settlement followed a special fraud alert released in August by the Department of Health and Human Services Office of the Inspector General warning that certain marketing practices that induce health care providers to prescribe drugs reimbursable by Medicare or Medicaid could violate the Medicare and Medicaid anti-kickback statute. The inspector general plans to target nonmedical benefits offered to physicians, suppliers, and patients in exchange for selecting specific prescription drug brands.

NATIONAL NEWS

Recap of State Votes

In **Oregon**, a proposal passed that allows physicians to give lethal drugs upon request to terminally ill adults. The AMA strongly opposed this proposition. In **California**, a proposal to bar the provision of non-emergency health care services to illegal aliens passed 51 to 41. Physicians opposed Proposition 187 because they said it would create a public health danger. The law bans the use of tax money to fight communicable diseases and other public health illnesses that affect illegal aliens. A federal district court judge has approved a restraining order temporarily blocking implementation of the ban. The proposal to create a government-financed health care system in California failed by 72 to 28 percent of the vote. In addition, an initiative pushed by Philip Morris was defeated that would have created a weak state anti-smoking law to preempt tougher local laws. In **Arizona**, a proposal to raise tobacco taxes by 40 cents a pack passed. The money will be used for health care services. A **Colorado** proposal to increase the tobacco tax by 50 cents failed. In **Arkansas**, a 2-cent tax on soft drinks to fund Medicaid was repealed. **Georgia** voters rejected a provision that would have eased antitrust laws.

Dental Clinic Fined for Refusing to Treat AIDS Patient

Castle Dental Center in Houston was ordered to pay $100,000 in damages and penalties for refusing to treat an HIV-positive patient. The settlement reached with the U.S. Department of Justice September 22 is the first AIDS-related settlement with a dental service under the Americans With Disabilities Act. U.S. District Judge Vanessa Gilmore also ordered the dental clinic to prohibit discrimination on the basis of HIV or AIDS and to train its staff about its non-discrimination policy.

Student Loan Deferment Restored

In a victory for medicine, the House and Senate adopted a measure ensuring that student loan deferment will remain an option for resident physicians who meet a fair "economic hardship" standard. The Elementary and Secondary Education Act (ESEA) of 1994 reverses the final regulations implementing the reauthorization of the Higher Education Act, which defined "economic hardship" as a percentage of the federal poverty level without considering the borrower's debt-to-income ratio. As a result of the ESEA, resident physicians will be able to seek deferment whenever their individual federal education debt burden equals or exceeds 20 percent of their adjusted gross income (AGI) and when their AGI minus federal education debt is less than 220 percent of the poverty level measurement.

ANTITRUST

AMA Calls Antitrust Harbors Too Narrow

The AMA says the new government guidelines on antitrust fall short of the protection physicians need to be players in a marketplace dominated by hospital and insurer networks. The Department of Justice and the Federal Trade Commission issued guidelines in late September that clarify antitrust safe harbors and give non-exclusive physician networks more leeway. Policy statements issued last year said that such networks avoided antitrust risk if their reimbursement structure encouraged physicians to keep costs and utilization low through captitation or fee withholds and if the network included fewer than 20 percent of the market's physicians in a given specialty. The new guidelines expand the safety zone to allow non-exclusive networks to include 30 percent of area physicians. But in markets with fewer than five physicians in a given specialty, a physician in that specialty can participate only on a non-exclusive basis. Although the guidelines name only capitation and withholds, they leave the door open for other forms of risk sharing. The new guidelines allow fee information to be shared by providers and payers under certain conditions, but a third party, such as a medical society, must collect the fee data. Any fee data given to other physicians must be at least three months old, and aggregate data must involve more than five physicians.

Justice Approves Kentucky Doc Network

The Justice Department on October 28 approved a joint venture involving more than 100 Kentucky physicians. The decision will allow Physician Care Inc. (PCI) in Bowling Green to contract with payers at capitated rates or on discounted fee-for-service rates. The network will hold in reserve 20 percent of the fee-for-service physicians' fees to distribute only if cost containment and utilization targets are met. PCI will be a non-exclusive network whose members may contract with competing providers. Justice approved this arrangement despite the fact that it would include 37 percent of area physicians, putting it outside the new safety zone of 30 percent of market share for non-exclusive physician networks that share risk.

FTC Opposes Antitrust Exemptions

The Federal Trade Commission (FTC) testified before the Vermont Legislature against a proposal to give the state's secretary of human services the power to grant antitrust immunity to cooperative agreements among health care providers. The FTC said there was a risk that the proposed "certificates of public advantage" would encourage arrangements that could reduce choices and raise prices.

DATA COLLECTION

Money Pledged to Data Institute

Money is flowing into the coffers of the Minnesota Health Data Institute from private sources. The MMA has pledged to contribute $2,000, the HMO Council has pledged $300,000, the Minnesota Hospital Association $200,000, and the Metropolitan Health Council $200,000. These organizations are contributing to the data institute to fulfill their bargain to form a public/private partnership with the state. The data institute will probably seek additional money from the Legislature this session.

Capital Expenditure Reports Are Public Data

Capital expenditure reports to the Minnesota Department of Health do not meet the legal definition of a trade secret and are, therefore, public data, according to an opinion issued by Commissioner of Administration Debra Rae Anderson on September 23.

To comply with MinnesotaCare law, health care providers must submit data on capital expenditures, including the actual dollar amounts associated with an individual capital expenditure. Commissioner of Health Mary Jo O'Brien requested an opinion on whether any of this data, particularly the dollar amounts, qualify for protection as trade secret information. The answer is no.

MDH Advised to Back Off on Data Collection

The Commissioner's Advisory Work Group on Health Data Initiatives has recommended that the Minnesota Department of Health scale back its data collection and analysis plans. The advisory work group, which was appointed in January by Mary Jo O'Brien, commissioner of health, found significant barriers to the state's ambitious data initiatives, including a lack of sufficient staff

DATA COLLECTION

and resources to carry them out and a lack of adequate measurement tools.

The report includes the following recommendations and opinions:

• Health data initiatives should be "population-based," including the entire population of a community rather than just individuals or enrollees of a single ISN or health plan company. This would avoid inappropriately labeling as "poor quality" those providers who treat a sicker population. It would also avoid incentives for ISNs to exclude high-risk patients.

• The MDH should not pursue the massive and expensive project of collecting detailed claims data on all health care services. Instead, the MDH should track expenditure growth though the summary reports that are currently required from health plans and providers.

• No current data set, including claims data, can accurately evaluate quality of care, produce report cards, evaluate access to health services, and monitor expenditure limits. The MDH should use disease-tracking systems and health status survey data to identify health problems in the population.

• It would be premature to use the current version of the Health Plan Employer Data and Information Set (HEDIS) to develop report cards that would hold ISNs accountable for their performance. The MDH should encourage ISNs to pursue internal continuous quality improvement activities consistent with public health goals.

• Risk-adjustment methods to set the premium levels and expenditure limits for ISNs and RAPO providers are not well enough developed at this point to assure that high-risk populations won't be excluded. As a long-term activity, the MDH should participate in national evaluation projects to improve risk-adjustment techniques and should continue the Risk Adjustment Technical Advisory Committee's work.

• Health plans should use quality, health status, and outcomes data for internal improvement activities, but should not disclose them to the public through report cards until there is valid and comparable data. Initially, report cards should include benefit levels, patient satisfaction, and access to care.

• The agenda of the Minnesota Health Data Institute should be scaled back and should focus on achieving short-term accomplishments.

Whether this advice will be followed remains to be seen.

• • • • • • •

MDH Stops Collecting Claims Data

The Minnesota Department of Health has decided to begin the process of repealing the rule requiring organizations to submit inpatient hospital claims data for 1994. After discussions with health plans, insurance carriers, and third-party administrators, the MDH concluded that because many organizations do not maintain claims data in a uniform format, it might be better to work with a smaller number of organizations to develop a uniform encounter level data set. Narrowing the scope and size of its data collection effort, the MDH intends to proceed with a pilot project, which will only affect a handful of organizations. The MDH has requested that organizations do not submit inpatient hospital claims data for 1994.

Provider Network Seminar Is January 11

The Minnesota Medical Association, the Minnesota Hospital Association, and the Minnesota Medical Group Management Association will present a seminar on cooperatives, clinics without walls, and other provider-directed networks January 11, 9 a.m. to 4 p.m., at the Northland Inn in Brooklyn Park. The registration fee is $75 for members and $125 for nonmembers. For more information, call Vicki Westling, 612/378-1875 or 800/999-1875.

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DECEMBER 1994

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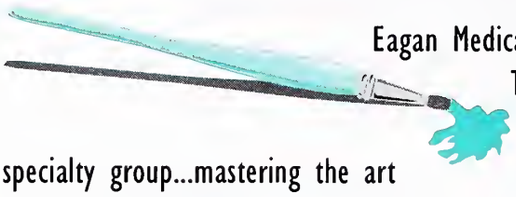

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Reducing Liability Risk in Managed Care

Physicians entering into managed care contracts can take a number of steps to reduce their risk of liability.

James B. Platt, J.D.

Minnesota physicians have front-line experience with managed care. Although a threat to some, managed care offers physicians and other providers new opportunities to form their own health plans and delivery systems. But many questions about managed care and these new systems remain unresolved. In particular, who will be liable if a treatment decision goes wrong? What responsibilities will physicians have if cost-containment goals conflict with optimal patient care? What liability will physicians face as they assume responsibilities previously handled by HMOs and insurance companies? And how can physicians protect themselves against these risks?

Liability Concerns

Few court decisions have involved physician liability under managed care, but this may change in the future. Managed care is growing rapidly across the country. Physicians may increasingly be named as defendants when patients do not receive the care to which they feel entitled. In addition, two federal appellate courts have refused to hold managed care companies liable for malpractice when they work for self-insured plans, ruling that such state law claims are precluded under federal employee benefits laws. Additionally, without a utilization reviewer to blame, some patients may turn against physicians and hospitals for recovery. And, as medical groups take on the dual role of provider and payer, plaintiffs may find fertile ground to allege conflicts between patient care duties, cost containment, and economic incentives.

Risk Management

Physicians entering into a managed care contract or designing a new delivery system should keep in mind the potential for liability. Physicians should always consult with legal counsel and risk management experts ahead of time. Some suggested precautions include the following:

Provide good medical care: Above all, physicians must continue to provide good medical care. If managed care offers an opportunity for financial gain, physicians must not allow economic factors to interfere with patient care.

The 1993 decision in *Fox v. HealthNet of California*[1] points out the dangers of creating the appearance that financial decisions dictate patient care. In this case, HealthNet, a for-profit HMO, was sued for refusing to pay for an autologous bone marrow transplant for an enrollee who subsequently died from breast cancer. Although HealthNet's policy listed bone marrow transplants as covered services, treatment was denied on the grounds that the procedure was experimental when attempted at later stages of breast cancer.

The estate, represented by the deceased enrollee's brother, showed that a HealthNet internal study had found that treatment prevailed at three of four other HMOs, and that in this case, the procedure was denied only after an executive at HealthNet changed his recommendation. Perhaps most damaging, however, was the plaintiff's argument to the jury that the executive received bonuses based upon the denial of costly medical procedures. Although the case was later settled on appeal for an undisclosed amount, the jury ordered HealthNet to pay almost $90 million in damages to the estate, including $77 million in punitive damages.

Although the patient's physician was not directly involved as a defendant, other cases have been filed against physicians and HMOs alleging that improper financial incentives led to negligent care.[2]

Inform patients of medical recommendations: If, for example, a patient's plan will not pay for additional hospital days, and the physician believes early discharge creates a risk, the physician should fully explain that risk to the patient.

Document recommendations and decisions: Physicians should objectively document in the patient's medical record the course of treatment recommended and the patient's decision. In doing so, physicians should be careful about how they express frustrations with the managed care plan. In one California case, the jury reportedly would have found the physician negligent (had he been a defendant) partly because the physician noted in the medical record that the patient had to be discharged "be-

cause of pressure" from the utilization review company.[3]

Challenge utilization reviewer decisions: Was the review decision made by qualified medical professionals? Was a denial for surgery or extended hospitalization reviewed by a licensed physician? Was a specialist involved? The most important case to date suggesting steps that physicians might take if treatment plans are denied is the mid-1980s California decision of *Wickline v. State*.[4] In that case, MediCal, California's Medicaid program, refused to grant a request for additional hospital days for Lois Wickline, who experienced complications following surgery to treat circulatory problems in her legs. Her treating physician requested an eight-day extension to her scheduled discharge date. However, MediCal approved an extension of only four days. Wickline was discharged after the four-day extension but had to be readmitted nine days later. Eventually, her leg was amputated. She brought suit against MediCal, alleging that the payer had been negligent in failing to approve the full eight-day extension. The California court ultimately held that MediCal could not be held liable for negligence in this case because the actual decision was made by Wickline's physician, not the payer. Although Wickline did not sue her physician, the court was greatly disturbed by the physician's conduct. The court noted that physicians have a responsibility to inform patients when they disagree with decisions regarding coverage.

Help patients take advantage of their right to appeal: Medical groups may need to help their patients take advantage of any appeal rights. Self-insured plans, in particular, must have an appeals process that the patient can initiate by written request.

Be certain the practice can meet patients' needs: Medical groups that sign capitated contracts or serve as gatekeepers should be careful that the practice can adequately address the needs of all expected patients. Communication between primary care physicians and outside specialists is also important. Groups must be careful if they are responsible for determining which specialists to refer to and when a referral is appropriate, particularly if the decision has a financial impact on the practice.

Maintain adequate malpractice insurance and be aware of policy exclusions: Policies typically do not cover nonmedical claims, such as defamation, breach of contract, and antitrust violations, which may be involved when providers do their own credentialling and utilization review.

Handle credentialling carefully: Medical groups that handle their own credentialling should carefully analyze how physicians are credentialled. In several cases, hospitals and HMOs have been found responsible for negligently credentialling and selecting physicians. In addition, the Medical Society of the District of Columbia just filed a lawsuit against a preferred provider organization alleging that the PPO falsely implied that doctors who were excluded lacked sufficient training and certification, did not meet community standards, and did not deliver cost-effective health care.[5]

Avoid using terms like "highest quality": Physicians should be leery of ad campaigns that present them as the "highest-quality" providers. Medical groups that consider the phrase harmless enough to use in a managed care contract may have held themselves to a higher standard and find they have more difficulty settling a case or defending a decision before a jury.

Choose the best organizational option: The type of legal organization and how the organization presents itself to patients may also affect liability. New legal entities such as limited liability corporations and limited liability partnerships may afford networks the ability to protect members from negligence committed by other members in the network.

Design cost-containment incentives so they don't influence patient care: Managed care organizations that work with capitated or risk-bearing medical groups are being advised to reduce their risk by disclosing that the gatekeeper or capitated physician is financially at risk for health care decisions.[6] This strategy may focus attention on the primary care group and how it makes referral decisions. An appeal mechanism involving outside physicians may benefit groups that conduct their own utilization review activities.

Have legal counsel review managed care contracts and new delivery arrangements: Overly broad indemnification clauses appear in many managed care contracts. These clauses can obligate the medical group to reimburse the managed care organization or network for legal fees and court costs if a claim results from the medical group's actions.

Conclusion

Unquestionably, while managed care presents new challenges and opportunities, physicians need to keep in mind that the law moves more slowly than market reforms. Legal principles that in the past have only applied to HMOs and hospitals may be used as new tools to allege liability in the future. Until the courts or Congress sort out the duties of the participants in these new systems, prevention will likely pay off later. MM

James Platt is a shareholder and officer of Fredrikson & Byron, P.A., and co-chair of its Health Law Practice Group.

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MMA Legal Compendium

The Minnesota Medical Association's 1994 Legal Compendium provides time-saving reference to Minnesota medical statutes and health care rules.

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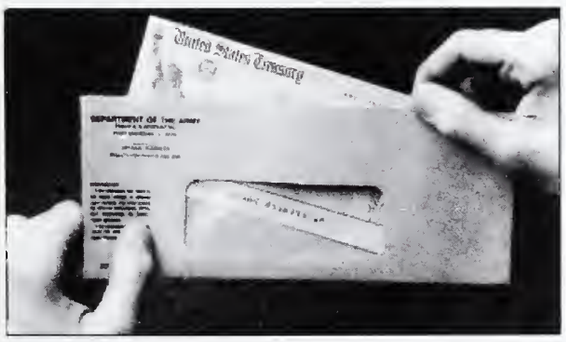

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Waldo P. Anderson, M.D.
University of Minnesota, 1932
Born: 1904, Notified: June 1994

Irving C. Bernstein, M.D.
University of Minnesota, 1943
Born: 1918, Died: June 22, 1994

Harry F. Bisel, M.D.
University of Pittsburgh, 1942
Born: 1918, Died: Sept. 2, 1994

Camillo V. Bologna, M.D.
University of New York, 1944
Born: 1919, Died: Nov. 27, 1993

Stephen J. Boros, M.D.
University of Illinois, 1966
Born: 1941, Died: July 23, 1994

C. Leon Cain, M.D.
University of Minnesota, 1933
Born: 1909, Died: Oct. 3, 1994

Dale H. Correa, M.D.
University of Michigan, 1942
Born: 1917, Died: Aug. 25, 1994

Mark B. Coventry, M.D.
University of Michigan, 1937
Born: 1913, Died: July 13, 1994

E. Dale Cumming, M.D.
University of Minnesota, 1952
Born: 1920, Died: Oct. 14, 1994

Thomas E. Dredge Sr., M.D.
University of Minnesota, 1929
Born: 1902, Died: April 1, 1994

John Dwyer, M.D.
University of Minnesota, 1945
Born: 1922, Died: Oct. 13, 1994

Victor K. Funk, M.D.
University of Minnesota, 1926
Born: 1899, Died: May 13, 1994

Norman Goldstein, M.D.
Geo. Washington S. of Med., 1946
Born: 1921, Died: Oct. 15, 1994

Warren W. Haesly, M.D.
Northwestern University, 1949
Born: 1924, Notified: June 5, 1994

Gerald L. Heideman, M.D.
University of Minnesota, 1947
Born: 1948, Died: Oct. 26, 1994

Claude R. Hitchcock, M.D.
University of Minnesota, 1945
Born: 1917, Died: Oct. 30, 1994

Richard Jackson, M.D.
Med. College of Wisconsin, 1946
Born: 1923, Died: Sept. 23, 1994

Walter H. Judd, M.D.
University of Nebraska, 1923
Born: 1898, Died: Feb. 13, 1994

Walter E. Krafft, M.D.
University of Minnesota, 1952
Born: 1928, Died: July 1, 1994

Richard J. Lien, M.D.
University of Minnesota, 1937
Born: 1910, Died: Mar. 23, 1994

Charles T. Louisell, M.D.
University of Minnesota, 1945
Born: 1917, Died: Jan. 23, 1994

Felix A. McParland, M.D.
Case Western University, 1950
Born: 1923, Died: May 25, 1994

William F. Mercil, M.D.
University of Minnesota, 1928
Born: 1903, Died: July 31, 1994

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University of Minnesota, 1930
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Orien B. Patch, M.D.
Case Western University, 1935
Born: 1909, Died: March 17, 1994

David G. Reque, M.D.
University of Iowa, 1961
Born: 1932, Died: Aug. 7, 1994

Curtiss Rockwell, M.D.
University of Minnesota, 1944
Born: 1919, Died: April 30, 1994

Reginald A. Salter, M.D.
McGill Univ., Montreal, 1926
Born: 1900, Died: Mar. 9, 1994

Frank V. Sander, M.D.
Columbia University, 1946
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University of Minnesota, 1958
Born: 1934, Died: Sept. 30, 1994

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University of Minnesota, 1941
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University of Michigan, 1941
Born: 1917, Died: May 20, 1994

John W. Warren, M.D.
Creighton University, 1954
Born: 1928, Died: Mar. 20, 1994

Clarence Watz, M.D.
University of Minnesota, 1943
Born: 1907, Died: Aug. 14, 1994

Marland R. Williams, M.D.
University of Minnesota, 1930
Born: 1899, Died: Aug. 22, 1994

People and Places Making Medical News

People

Helpern Laureate

John I. Coe, M.D., was named Helpern Laureate by the National Association of Medical Examiners for his exceptional contributions to the forensic pathology field. Coe was Hennepin County Medical Center's chief of pathology for 33 years and Hennepin County medical examiner for 20 years.

Minneapolis Award

Family physician **Eugene Ott, M.D.**, received the Minneapolis Award, which recognizes exceptional efforts to ensure the city's vitality and continual improvement. Ott was honored primarily for his leadership of Hennepin County Medical Society's involvement in the Success by 6 Program, which helps increase access to prenatal care.

AAFP Board Member

Lynne B. Lillie, M.D., has been elected to the board of directors of the American Academy of Family Physicians. Lillie, a family practice resident at the University of Minnesota Department of Family Practice and Community Health, is the board's only resident member. She is completing her family practice residency at St. John's Hospital in Maplewood.

Allina Management Team

Allina has appointed six system vice presidents to its senior management team. Several of the appointees will fill roles similar to their former positions at HealthSpan Health Systems Corp. and Medica. Allina Health System, the nonprofit integrated health care system, was formed in July by the merger of HealthSpan and Medica.

The vice presidents are: **Richard S. Blair**, system vice president, Finance and Administration; **Linda M. Lee**, system vice president, Communications; **Steven G. Hillestad**, system vice president, Marketing and Strategic Planning; **Michael W. Howe, Ph.D.**, system vice president, Human Resources; **Jan K. Malcolm**, system vice president of Public Affairs and vice president of Community Affairs; and **Mark G. Mishek**, system vice president, Legal, and general counsel.

HealthSystem Minnesota Restructure

HealthSystem Minnesota is implementing an organizational restructure that includes new senior leadership appointments. The restructure also includes identification of six business units to lead operations for HealthSystem Minnesota and its subsidiaries: Methodist Hospital, Park Nicollet Medical Center, Methodist Hospital Foundation, HSM Associates, and two new units, retail operations and regional services. Hospital and clinic operations will remain under separate leadership.

The following individuals will lead the six units: **Terry S. Finzen**, senior vice president and chief operating officer for Methodist Hospital; **Richard J. Migliori, M.D.**, senior vice president and chief operating officer for Park Nicollet Medical Center; **Mark S. Fisher**, vice president and chief administrative officer of Park Nicollet operations; **Geoff Kaufmann**, vice president and chief operating officer for Regional Services of HealthSystem Minnesota; **Dwayne J. Broe**, vice president and chief operating officer for HealthSystem Minnesota's Retail Services; **John W. Herman**, vice president and chief operating officer for HSM Associates; and **Rodney R. Dueck, M.D.**, system medical director of HealthSystem Minnesota. **Michael J. Johnson** continues his role as head of the Methodist Hospital Foundation. HSM also appointed **David K. Wessner** as executive vice president of its system and staff services.

Medical Alley Board Members

Medical Alley elected new board members and officers at its annual meeting in October. The St. Louis Park-based trade association for the state's health care industry elected the following people to its board as directors: **Bob Elgin**, vice president of operations at St. Jude Medical, Inc.; **Terry Finzen**, senior vice president and chief operating officer, Methodist Hospital; **Marcus Merz**, president and chief executive officer, PreferredOne Management Corporation; **Anil Rastogi**, executive vice president, SIMS Deltec; **Jim Thompson**, president, Genetic Laboratories Wound Care; and **Jay Warren**, vice president of product development, Cardiac Pacemakers.

Elected officers are as follows: board chair, **Peter Boman, M.D.**, orthopedist and chair of The Duluth Clinic board; first vice chair, **Donald Maurer**, chair of EMPI, Inc.; second vice chair, **James Dixon**, president and chief executive officer, St. Paul-Ramsey Medical Center; third vice chair, **Marlene Travis**, president and chief operating officer, Health Risk Management; secretary, **Jerry Haarmann**, chief executive officer, Memorial Blood Center of Minneapolis; treasurer, **David O'Brien**, partner, KPMG Peat Marwick; counsel, **Margo Struthers**, attorney, Oppenheimer, Wolff, and Donnelly; and president, **Thomas Meskan**, Medical Alley.

Places

Park Nicollet Receives C. Everett Koop Award

Park Nicollet Medical Foundation's Health Education Center

received a 1994 C. Everett Koop National Health Award in October. The award, given to nine recipients in the health education field, recognizes health promotion and disease prevention programs that have demonstrated savings from improved health behaviors. Park Nicollet received this award for its self-care series of brochures. The award program is sponsored by The Health Project, a White House-endorsed, public-private coalition formed to lower health care costs through "demand reduction," which encourages all members of the community to collaborate in reducing costly health care.

Gillette Receives PR Award

The American Society for Health Care Marketing and Public Relations of the American Hospital Association honored Gillette Children's Hospital in St. Paul with a silver award in the category Best Public Relations or Marketing Program for a Small or Rural Hospital. Kathryn Wardrop, vice president of marketing for Gillette, and her colleagues were recognized for their epilepsy education and curriculum program. The annual Touchstone Awards recognize health care marketing and public relations efforts across the nation.

Children's-St. Paul Awarded Grant

Children's-St. Paul was awarded a $70,000 grant from the John S. and James L. Knight Foundation to support the hospital's immunization efforts. Among Children's many initiatives, it developed the campaign "5 B4 2: Make sure your kids get five sets of shots before they're 2." The hospital also spearheaded the Children's Immunization Project in 1992, a coalition of private and public health care providers and social service organizations collaborating to increase child immunization rates. Next year it will launch a computerized tracking program to ensure timely child immunizations.

Abbott Starts New Pain Program at Sister Kenny Institute

Abbott Northwestern Hospital has implemented a new day program for people experiencing moderate pain, such as back, neck, upper or lower extremity, or cancer-related pain. The program, to be held twice a week for six weeks at the Sister Kenny Institute, is for those who experience pain that interferes with their work or school activities. The program will use the same staff and components of the hospital's existing Chronic Pain Program and will offer therapies ranging from the traditional to innovative, such as exercise physiology, psychological services, and biofeedback. The Chronic Pain Program was the first of its kind in the Upper Midwest.

Virginia Piper Cancer Institute Opening Breast Center

The Virginia Piper Cancer Institute at Abbott Northwestern Hospital announced plans to open a new breast center in January 1995. The Piper Breast Center will expand and centralize the hospital's current breast care services. The new center will offer routine screenings, assessment, rapid diagnosis, family and genetic counseling, treatment planning, and support programs.

"We are going to provide a more efficient, less stressful, patient-friendly approach to the diagnosis and treatment of breast cancer," said John Brown, M.D., oncologist and acting medical director of the Piper Breast Center, in an October news release.

State's First Provider Co-op

Numerous physicians, hospitals, and clinics across the state have announced their intention to incorporate as a health care provider cooperative, called Quality Health Alliance. The 146 physicians, nine hospitals, and 21 clinics filed papers that, if approved, will make them the first group in the state to form a cooperative as described in the Minnesota Health Care Cooperative Act, found in 1994 MinnesotaCare legislation. Quality Health Alliance will provide health care services and function like a traditional co-op, providing its specialized services or products to consumers. "A provider co-op is a way providers can get together so they can sell their services to a CISN, an ISN, or someone else who wants to buy them," said James Matthews, an attorney with Lindquist & Vennum, in an October 28 *CityBusiness* article.

HealthEast Acquires Dakota Clinic

HealthEast has acquired the Dakota County Internal Medicine Clinic in South St. Paul, bringing its total clinic ownership to 18. The agreement between HealthEast and Dakota County Internal Medicine Clinic will not affect current relationships or contracts with insurers or health maintenance organizations, according to an October press release by HealthEast.

The Dakota County Internal Medicine Clinic is located in the medical building on the campus of the former HealthEast Divine Redeemer Hospital.

Health Dimensions Buys Ebenezer Center

Health Dimensions Inc. has purchased Ebenezer Caroline Center in south Minneapolis. The long-term and subacute care facility, which Allina Health System sold for $3 million after the Ebenezer Society ended its lease, will be renamed City of Lakes Transitional Care Center.

The center no longer fit with the Ebenezer Society's strategy, which is to provide its services in campus settings that include not only nursing homes, but also senior housing that's supported by community services, according to Mark Thomas, chief executive officer of Ebenezer in an October *CityBusiness* article. Ebenezer currently owns 14 senior housing facilities and three nursing homes and is planning construction on a senior housing facility next to Ebenezer Ridges, a nursing home in

Burnsville.

Health Dimensions Inc. will maintain the services the center previously offered and add new programs. This center will be Health Dimension's first subacute or transitional care facility, although it owns or operates 14 long-term care facilities in Minnesota.

Socioeconomics

Group Health Eliminates Seniors Plus

HealthPartners is eliminating its Group Health Seniors Plus plan and offering a less expensive plan that eliminates the $7,000 long-term, in-home care benefit. HealthPartners is helping the approximately 500 seniors receiving the long-term care benefit come up with other funds to cover home care, such as state government funding. Seniors Plus, a demonstration program for the past nine years, lost more than $15 million since it began in 1985, said Kirby Erickson, executive vice president for HealthPartners.

The new plan replacing Seniors Plus, known as HealthPartners' SeniorChoice Advantage plan, will cost $142.95 per month with no office visit copayments. (Many Seniors Plus members protested last year when the company added office visit copays to the program.) It will cover prescription drugs with a $10 copay and will include preventive dental care and minor changes in eyeglass and hearing aid coverage.

HealthPartners is also adding HealthPartners SeniorChoice with a monthly premium of $85, and it will continue to offer its basic $60 per month Group Health Seniors plan.

Health Department Report Compares HMOs

The Minnesota Department of Health issued its first performance comparison of the state's HMOs in October. The report analyzes five preventive measures—prenatal care, infant immunizations, screening with Pap tests, mammography exams, and cholesterol readings—for 12 HMOs.

Central Minnesota Group Health Plan had the highest percentage of patients receiving recommended immunizations by age 2 (95 percent) and Blue Plus had the lowest (75 percent). HealthPartners had the highest percentage of prenatal care in the first trimester (96 percent), and Blue Plus had the lowest (86 percent). MedCenters had the highest rates of mammography

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(689 tests per 1,000 female enrollees 50 and older), and Northwestern National Life Insurance Company had the lowest rate (457).

Officials emphasize that this is the state's first attempt to compare Minnesota's HMOs, so the rating system is not perfect.

Steve Richards, vice president and medical director for Blue Plus, said its numbers are not comparable with the rest because only 20 percent of its members were included in the report; the majority work for self-insured companies that are not required to provide data to the Health Department. He said larger companies have different benefits packages and tend to emphasize wellness programs, so "we expect the numbers would be different."

Hennepin Starting Needle Exchange Program

The Hennepin County Board voted 5-2 in October to approve a syringe-exchange program in Minneapolis to help prevent the spread of AIDS. The Minnesota AIDS Project will operate the program for three years at a cost of $410,000. It will encourage addicts to enter drug treatment and will educate them about needle-borne transmission of the AIDS virus and other diseases.

The program will operate initially out of two sites (eventually five), one on the near north side of Minneapolis and another in south Minneapolis. In addition, a mobile van will operate from the two sites for three hours a day, three or four days a week. Supporters hope to reach at least 150 drug abusers weekly.

MHCC Considers MinnesotaCare Funding Options

The Minnesota Health Care Commission, in a search for alternative sources to fund MinnesotaCare, is considering such proposals as taxes on guns and ammunition, lottery tickets, and attorney's fees in malpractice cases; increased excise taxes on alcoholic beverages and cigarettes; and higher income taxes. As *Minnesota Medicine* goes to press, the commissioners are brainstorming options without considering whether they are politically acceptable. The commissions' preliminary sketch suggests that a tax on guns and ammunition is likely to face opposition from special interest groups, and there is no estimate on how much revenue such a tax could raise. A 6.5 percent sales tax on lottery tickets would raise $21.5 million, but about 55 percent of the cost of tickets already supports state programs.

Local Companies Offer Domestic Partner Benefits

Three Twin Cities companies have decided to offer benefits, including health and dental benefits, to same-sex or unmarried heterosexual partners of employees as of January 1. The St. Paul Companies, Northern States Power, and the Wilder Foundation were honored by the Gay, Lesbian, Bisexual, Transgender Workplace Council in October for their decision.

Park Nicollet Medical Center plans to offer similar benefits to its employees after adapting its payroll computer system. Park Nicollet, however, is not offering unmarried heterosexual partners health, dental, and dependent life insurance coverage, because these couples have the legal option to marry, said Cornell Anderson, a benefits management consultant and former Park Nicollet human resources manager.

Rates, Trends, Data

Minnesota Slips to Second Healthiest State

Minnesota has slipped from first to the second healthiest state in the nation because of apparent increases in smoking, risk of heart disease, and infectious disease, according to Northwestern National Life Insurance Co., based in Minneapolis.

While national smoking rates dropped, Minnesota's rate increased from 21.4 percent to 23.3 percent, according to the 1991 Behavioral Risk Factor Surveillance survey from the Centers for Disease Control and Prevention (the latest numbers available when the study was prepared). The national average was 23 percent. The study ranked Minnesota 26th in smoking prevalence.

The risk factors for heart disease (obesity, high blood pressure, and sedentary lifestyle) increased in Minnesota, as did the number of infectious diseases (AIDS, tuberculosis, and hepatitis).

Nonetheless, Minnesota still ranked high in most categories used in the analysis. It had the highest rate of high school graduation (89.2 percent), a ranking used because educated people tend to seek health care earlier. Minnesota ranked second lowest in total mortality, work disability, and heart disease, and fourth lowest in the rate of motor-vehicle deaths.

The healthiest state in the nation is New Hampshire. Utah and Connecticut tied for third, and Hawaii was fourth. The states with the worst rankings were Louisiana (the lowest rank), followed by Mississippi, West Virginia, South Carolina, and Arkansas.

Male Teen Death Rate Increases

In 1991, 154 percent more adolescent boys were killed than in 1985, with 97 percent of the increase in homicide attributed to firearms, according to a study released by the Centers for Disease Control and Prevention. "This shows clearly and comprehensively that we have an epidemic of firearms death among young men," said Mark Rosenberg, M.D., Ph.D., director of the National Center for Injury Prevention and Control, a division of the CDC. The study showed the largest increase for annual rate of deaths (154 percent) for boys aged 15 to 19. The study also reported that while homicide arrests rates for boys 15 to 19

years old increased 127 percent from 1985 to 1991, they dropped 1 percent for men 25 to 29 years old and dropped 13 percent for men 30 to 34 years old.

Law & Policy

Toddler Awarded Millions

A Ramsey County District Court jury ordered the North End Medical Center in St. Paul to pay 4-year-old Amber Jonas $4.4 million in one of the largest medical malpractice awards in state history. Jonas was awarded the settlement for permanent injuries incurred from oxygen starvation prior to her birth. The jury found the clinic staff and its nurse midwife negligent in attending to Jonas' mother, Lynda Judd, who came into the clinic six months pregnant and complaining of chest pain. Judd was left unattended in a room at the clinic, where she went into cardiac arrest. She was rushed to the hospital but pronounced dead shortly after Amber was delivered in an emergency cesarean section.

Amber suffered injuries to her brain stem and spent her first three years on a respirator and is still dependent on a feeding tube. She is being raised by a foster mother. Part of the award will be used to pay off the state of Minnesota, which has paid $1.6 million in medical expenses for the child. After medical and legal expenses have been paid, the remainder of the settlement will be put into a trust for Amber.

Medical Research

Fish Oil May Slow Kidney Disease

Fish oil, touted of late as beneficial in reducing heart attacks and lung disease, appears to slow the progress of kidney disease, according to a study published in the November 3 *New England Journal of Medicine*. The two-year Mayo Clinic study of 21 kidney specialty centers in Minnesota and the Midwest included 106 patients with idiopathic IgA nephropathy—an autoimmune disease in which the body's disease-fighting cells destroy the kidneys. Slightly more than half the patients were given daily doses of a highly purified fish oil—provided by the National Institutes of Health—while others were given a placebo. After four years, 40 percent of those given the placebo had died or had end-stage renal disease, compared with only 10 percent of those given the fish oil. MM

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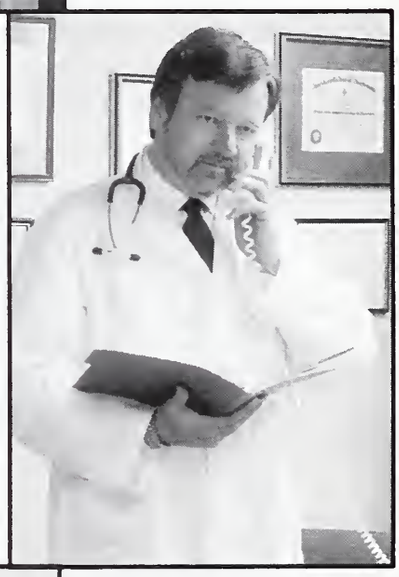

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WETZELL

(continued from page 7)

providers a clear set of financial incentives," he says.

Practice Standards and Cultural Change

Developing practice standards, Wetzell believes, is one of the essential tools for success of the BHCAG project. The consortium developed 16 practice standards in 1993 and 10 more this year.

Practice standards have been derided in the past as "cookbook medicine," but Wetzell says one thing he's been most pleased with is the providers' enthusiasm for working together to develop the new standards. The difference, he says, might be that providers are developing the standards rather than outsiders imposing standards upon them.

"It's the difference between creating incentives to get the system to control cost and quality on its own vs. hiring an inspector to try to control cost and quality after the fact," he says. "Now we've gotten smart enough that we don't want to hire inspectors anymore. We want physicians to take control of their destiny. In exchange for getting that discretion back into the system—where the physician defines how to treat the patient—they're going to have to take some shared financial risk."

The Data Challenge

Wetzell is also a firm believer in the value of data to help maximize quality at the lowest possible cost. But, he says, the data piece in the BHCAG solution is one of the greatest challenges. "We want the providers to develop a clinical system that gathers data to help them understand treatment variations—what works best and what doesn't," he says. "That's a long-term goal."

The system would be very different from current payer-based systems that government, HMOs, and insurance companies use to review utilization for the purpose of reimbursement. Instead, BHCAG is working with providers on collecting data using an automated medical record system that will analyze practice patterns and help physicians define the highest quality, most cost-effective treatment standards.

But while Wetzell isn't afraid to dream of the prospects of such a system, he's pragmatic enough to see the barriers—namely cost.

"The product doesn't exist yet, and it represents a huge capital investment. So we need somebody to put the development costs forward to get the bugs out of the system and help build something that's affordable," he says.

Competition at the Right Level

The action group currently is considering two important steps: how to expand its provider network and how to offer a second, competing product to its members.

"That represents another big challenge," he says. "We're trying to restore the proper balance of power between care systems, health plans, purchasers, and consumers so that the health plans don't play the dominant role in the market."

That means creating competition at the right level of the system—the network level—rather than underwriting, cost shifting, and simply ratcheting down on provider reimbursement. It's a delicate balancing act. And Wetzell is looking toward the power of the market—not the mandate of government—for the solution. "We're looking at what steps we can take and how we can structure our contracts to make sure the competition is at the level of the integrated delivery system," he says.

Here, Wetzell disagrees with aspects of MinnesotaCare and some of the work of the state Health Care Commission. "Although we agree conceptually with the concept of integrated service networks, we disagree with the amount of regulation they've created and the price controls they've overlaid on the system," he says.

The Pressure of Leadership

Wetzell is comfortable with the attention BHCAG has received from national media because the action group considers this a demonstration project. But he feels a sense of urgency about achieving success. "I believe in a market-based system," he says. "But I don't think we have forever to prove it's a model that will work before we have more and more demands for government to regulate the heck out of us." MM

Thomas Allen is a Minneapolis-based free-lance writer.

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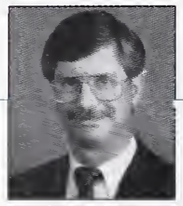

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JANUARY 1995

Jan. 20-22 **Mid-Minnesota Medical Symposium for Primary Care Physicians** St. Cloud Hospital; Holiday Inn, St. Cloud, MN. CONTACT: Deb Hardy, Medical Staff Office, 1406 Sixth Avenue North, St. Cloud, MN 56303; 612/255-5626.

FEBRUARY 1995

Feb. 1-8 **Update in Clinical Neurophysiology** Mayo Foundation; Mayo Foundation, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Feb. 3 **1995 Rheumatology Conference–Duluth Clinic** Duluth Clinic; Fitger's Spirit of the North Theatre, Duluth, MN. CONTACT: Rockie Odberg, 400 East Third Street, Duluth, MN 55802; 218/725-3838.

Feb. 4-8 **Selected Topics in Internal Medicine** Mayo Foundation; Silverado Resort, Napa Valley, CA. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Feb. 9-11 **Mayo Clinic State-of-the-Art Symposium: Arrhythmia Management** Mayo Foundation; Silverado Resort, Napa Valley, CA. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Feb. 10 **Burn Care Today** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Feb. 15-19 **Pain Management Conference** MeritCare; Big Mountain, Whitefish, MT. CONTACT: Sue Heinze, 720 Fourth Street North, Fargo, ND 58008; 701/234-5737.

Feb. 24 **Through the Eyes of Others: Is Health Care Culturally Competent?** Hennepin County Medical Center; Earle Brown Continuing Education Center, St. Paul Campus, St. Paul, MN. CONTACT: Ann Samways, HCMC/HFA Office of Academic Affairs, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415-1829;612/347-2078; or Robin Hoppenrath, 612/337-7128.

MARCH 1995

Mar. 9-10 **Family Medicine Today** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Mar. 17 **Occupational Medicine Update** St. Paul-Ramsey Medical Center; Sheraton Minneapolis Metrodome, Minneapolis, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Mar. 24-26 **Advances in Clinical Anesthesiology** Mayo Foundation; Silverado Resort, Napa Valley, CA. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Mar. 30-31 **Critical Care 1995** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Mar. 31 **John I. Coe Symposium** Hennepin County Medical Center; Hennepin County Medical Center, Minneapolis,

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DECEMBER 1994

Dec. 9 **Antibiotic Resistance: Immediate Implications** Allina; United Hospital, St. Paul, MN. CONTACT: Don Young, Allina, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

Dec. 14 **Symposium on Infectious Diseases** Duluth Clinic and Miller-Dwan Medical Center; Miller-Dwan Medical Center, Duluth, MN. CONTACT: Linda Kratt, 502 East Second Street, Duluth, MN 55805; 218/720-1112.

JANUARY 1995

Jan. 11 **Symposium on Infectious Diseases** Duluth Clinic and Miller-Dwan Medical Center; Miller-Dwan Medical Center, Duluth, MN. CONTACT: Linda Kratt, 502 East Second Street, Duluth, MN 55805; 218/720-1112.

MARCH 1995

Mar. 24 **The Primary Care of HIV 1995** Allina; Holiday Inn International, Bloomington, MN. CONTACT: Don Young, Allina, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

MN. CONTACT: Ann Samways, HCMC/HFA Office of Academic Affairs, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415-1829; 612/347-2078; or Robin Hoppenrath, 612/337-7128.

APRIL 1995

Apr. 6-7 **Ob/Gyn Update** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 6-9 **Second International Conference on the Medical Aspects of Telemedicine and Second Annual Mayo Telemedicine Symposium** Mayo Foundation, World Health Organization, and the Agency for Health Care Policy and Research; Rochester, MN, Scottsdale, AZ, and Jacksonville, FL. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Apr. 7 **ENT for Primary Care Physicians** St. Paul-Ramsey Medical Center and HealthEast; St. Joseph's Hospital, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 8 **Problems in Clinical Anesthesia–Department of Anesthesiology Clinical Symposium** University of Minnesota Anesthesiology Department; Radisson Metrodome, Minneapolis, MN. CONTACT: David S. Beebe, M.D., Box 294, B515 Mayo, Department of Anesthesiology, 420 Delaware Street SE, Minneapolis, MN 55455; 612/624-9990.

Apr. 28-29 **Minnesota Orthopaedic Society Eleventh Annual Meeting** Minnesota Orthopaedic Society; Minneapolis Convention Center, Minneapolis, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875 or 800/999-1875.

MAY 1995

May 6 **A Current Update on Evaluation and Treatment of Infertility** Minnesota Urological Society; Mayo Clinic, Rochester, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875 or 800/999-1875.

May 18-19 **Spring Refresher** Minnesota Academy of Family Physicians; Hyatt Regency Hotel, Minneapolis, MN. CONTACT: Minnesota Academy of Family Physicians, 600 South Highway 169, Suite 1680, St. Louis Park, MN 55426; 612/542-0130 or 800/999-8198.

JUNE 1995

June 2-3 **Phonosurgery: Indications and Techniques** Hennepin County Medical Center; Hennepin County Medical Center, Minneapolis, MN. CONTACT: Ann Samways, HCMC/HFA Office of Academic Affairs, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415-1829; 612/347-2078; or Robin Hoppenrath, 612/337-7128.

OCTOBER 1995

Oct. 26-27 **Trauma Management for Primary Care Providers** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

NOVEMBER 1995

Nov. 16-18 **Strategies in Primary Care Medicine** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

DECEMBER 1995

Dec. 7-9 **Cardiopulmonary Medicine** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

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General Surgeon, Family Practice, Ob/Gyn, Internal Medicine to join progressive 13-physician group practice. Rural college town 30 miles from St. Paul, Minnesota. New clinic and new hospital. Contact: Robert B. Johnson, M.D., River Falls, WI 54022; 715/425-6701. (*5/94-R)

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Family Physicians, P.A., 612/835-3609, or send inquiries to 7801 East Bush Lake Road, Suite 400, Bloomington, MN 55439. (*3/93-R)

Mankato Clinic, Ltd. is seeking additional BC/BE physicians in the following specialties: orthopedics, radiology, invasive cardiology, oncology/hematology, family practice, and general internal medicine. The Mankato Clinic is a 59-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. M. P. Wheeler, President, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (10/93-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

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Olmsted Medical Group is seeking BC/BE physicians in the following specialties: emergency medicine and ob/gyn. Great opportunity for well-trained physicians to join a 70-physician multispecialty group in a dynamic, progressive practice. In addition to the main office in Rochester, the group operates eight branch offices in southeastern Minnesota. Excellent salary/benefits package includes malpractice insurance, flexible benefits plan, 401(k) and profit sharing, and relocation assistance. Send CV to Olmsted Medical Group, Attn: Susan Schuett, 210 Ninth Street SE, Rochester, MN 55904. (1/92-R)

Internal Medicine and Dermatology practice opportunities available at the Faribault Clinic. The Faribault Clinic is a multispecialty group practice of 18 physicians. Faribault is located 50 miles south of Minneapolis on I-35. For more information contact Ray W. Wood, M.D., or Ken Smith, Administrator, 924 NE First Street, Faribault, MN 55021; 507/334-3921. (4/94-R)

Stillwater: 20-physician multispecialty group with emphasis on primary care seeking BC/BE family physician. Scenic location with excellent school system, supportive medical community with strong local hospital, competitive salary and benefits. Send CV to Jon Pedersen, St. Croix Valley Clinic, 921 South Greeley, Stillwater, MN 55082; 612/439-2215. (9/93-R)

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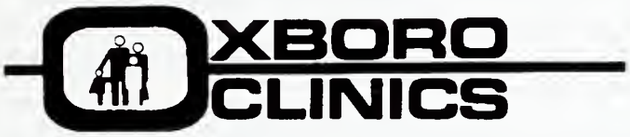

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